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ABSTRACT

Text of a Congressional hearing examining the 10-year-old Long-Term-Care Ombudsman Program funded under the Older Americans Act is presented in this document. Opening remarks are given by Representatives Wyden, Snowe, Biaggi, and Robinson. Witnesses testifying include: (1) Michio Suzuki, Associate Commissioner, Office of State and Tribal Programs, Administration on Aging; (2) Charlotte Rosenfield, daughter-in-law of a long-term care facility resident; (3) Janet Tulloch, long-term care facility resident; (4) Arthur Flemming, former U.S. Commissioner on Aging, and father of the Ombudsman Program; (5) Shirley A. Ellis, director of ombudsman services, Wisconsin Board on Aging and Long-Term Care; (6) Jim Varpness, president, National Association of State Long-Term Care Ombudsman Programs and Minnesota State Ombudsman; (7) Julie Trocchio, director, delivery of services, American Health Care Association; (8) Elma L. Holder, executive director, National Citizens' Coalition for Nursing Home Reform; and (9) Wilda Ferguson, commissioner, Virginia Department on Aging and first vice president of National Association of State Units on Aging. Appendices include additional relevant material submitted for the record consisting of statements, letters, and reports. (ABL)

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THE LONG-TERM CARE OMBUDSMAN PROGRAM: A DECADE OF SERVICE TO THE INSTITUTIONALIZED ELDERLY

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN SERVICES

OF THE

SELECT COMMITTEE ON AGING

HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

SEPTEMBER 10, 1985

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THE LONG-TERM-CARE OMBUDSMAN PROGRAM: A DECADE OF SERVICE TO THE INSTITUTIONALIZED ELDERLY

TUESDAY, SEPTEMBER 10, 1985

House of Representatives,
Select Committee on Aging,
Subcommittee on Human Services,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:01 a.m., in room 210, Cannon House Office Building, Hon. Ron Wyden (acting chairman of the subcommittee) presiding.

Members present: Representatives Wyden, Synar, Robinson, and Snowe.

Staff present: Teresa Karamanos, assistant staff director; Barbara Kaplan, minority staff director; Bente Cooney, minority research assistant; Vicki Wilde, intern; and Sandra McMillen, intern; of the Subcommittee on Human Services; Karen Kaplan, health associate; and Mark Kirchmeier, legislative assistant, Representative Wyden's staff.

OPENING STATEMENT OF REPRESENTATIVE RON WYDEN

Mr. Wyden. The subcommittee will come to order. Today the subcommittee is convened to examine the Long-Term-Care Ombudsman Program that is funded under the Older Americans Act. The program is now 10 years old, and it seems particularly appropriate for the subcommittee to examine its accomplishments, its limitations, and consider where we go from here.

What's most appealing about the ombudsman idea is that it provides a grassroots forum for patient, family, friends, and nursing home staff to work cooperatively to improve long-term care. Through this process our society has been able to empower some of our most powerless citizens. It gives our society a chance to break down the barriers of fear and retaliation, and it gives nursing home residents who cannot sift through the tangle of law books and technical Government language a tool to secure their rights.

Today we see new opportunities and challenges for ombudsmen. The older segment of America's population—people older than 75—is growing faster than any other age group. One out of five of those people older than 85 will need long-term care, and many of these will receive care in new settings such as their homes. The original legislation—Ombudsman Program—does not cover home health agencies.

We hope to hear today from witnesses about whether they think the ombudsman concept should be extended to home health care programs, to programs for the handicapped and disabled, and to other types of long-term care.

We're going to look at a variety of other issues as well, such as the degree of independence given to ombudsman in their home States. Only 13 States have ombudsman working independently of their State agencies on aging. In a lot of instances more independence can mean more effectiveness.

We also wish to look this morning at the support the Administration on Aging has given the program. Is the Administration, in fact, giving the technical assistance and information to the ombudsman that they need.

Personally, I've been interested in this effort for a number of years since my days as codirector of the Oregon Gray Panthers. I felt for a long time that the key to better nursing home care in this country is not necessarily more laws and more regulations, but generating more grassroots local involvement in improving nursing home care.

I think it's fair to say that the Ombudsman Program provides just the kind of opportunity.

Finally, I'd like to thank Chairman Biaggi, who unfortunately can't be with us, for convening this hearing and for the tremendous leadership that he's given to the cause of personally advocating for older people. I would also like to thank my colleague, Olympia Snowe from Maine, who has a long and very distinguished record working for the rights of older people in her State, and around this country.

Let me now recognize my colleague for whatever comments that she would like to make.

STATEMENT OF REPRESENTATIVE OLYMPIA J. SNOWE

Ms. Snowe. I thank the chairman for his comments. I'd like to ask unanimous consent to include my entire statement in the record.

I would just like to say that I am pleased to take part in this hearing on the Long-Term-Care Ombudsman Program. The well-being of the institutionalized elderly has long been a concern of mine, and as a ranking member of this subcommittee I am mindful of the responsibilities that we have with respect to oversight to the Older Americans Act. Additionally, I think it is fitting that we should mark this tenth anniversary by evaluating the progress of the Ombudsman Program with a view to the future.

Quality of care is what the Long-Term-Care Ombudsman Program is all about. The program was originally started because nursing home residents were not always guaranteed the quality of care that they deserved. Nursing home scandals made it apparent that a program designed to give the residents a voice, and the opportunity to air their grievances, was sorely needed.

In my own State of Maine, we've had a very effective Ombudsman Program. Maine does not have a substate network of Ombudsman Programs, but instead has a centralized program that is unique in that it is one of the few independent programs in this country. That is to say that the Ombudsman Program has been subcontracted by the State agency on aging to an independent agency not associated with the department which licenses, regulates, and reimburses nursing homes and boarding homes.

I'm also pleased to say that in my State legislation has been passed not only to provide the ombudsman access to residents in the nursing homes, but also to allow the ombudsman to inspect and copy all records pertaining to the resident. That authority is, of course, very important and very effective in investigating complaints.

Again, Mr. Chairman, I'm pleased that we're holding this hearing today. I'm looking forward to the testimony of the witnesses that will be forthcoming.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Snowe follows:]

PREPARED STATEMENT OF REPRESENTATIVE OLYMPIA J. SNOWE

Thank you, Mr. Chairman. It is a pleasure to take part in this hearing on the Long-Term Care Ombudsman Program. The well-being of our institutionalized elderly has long been a concern of mine. As the ranking member of this Subcommittee, I am mindful of the oversight responsibility that we have for the Older American's Act. Thus it is fitting that we should mark this 10th anniversary by evaluating the progress of the Ombudsman Program, with a view to the future.

Quality of care is what the Long-Term Care Ombudsman Program is all about. The program was originally started because nursing home residents were not always guaranteed the quality care that they deserved. Nursing home scandals made it apparent that a program designed to give the residents a voice and the opportunity to air their grievances was sorely needed.

In my own state of Maine, we have a very effective Ombudsman Program. Maine does not have a substate network of Ombudsman Programs. Rather, the program is centralized and directed by the State Ombudsman, who in turn directs 25 highly trained volunteers. When a complaint is received from nursing home residents or their families, one of the volunteers is alerted by the State Ombudsman and is asked to investigate the complaint. I am proud of the fact that Maine is one of the few states which has an independent program; that is, the Ombudsman Program has been subcontracted by the State Agency on Aging to an independent agency not directly associated with the department which licenses, regulates and reimburses the nursing and boarding homes.

I am also pleased that Maine has passed legislation which not only gives the Ombudsman access to residents, but also allows the Ombudsman to inspect and copy all records pertaining to a resident. This is very important, because I understand that in many states the Ombudsman does not have the authority to look at the patient's records, which can make investigating a complaint very difficult.

Thank you again, Mr. Chairman. I look forward to hearing the testimony of today's witnesses.

Mr. **WYDEN**. I thank my colleague for her leadership and for an excellent statement.

Before we hear our first witness I would like to submit the prepared statement of Chairman Mario Biaggi for inclusion in the hearing record at this point. Hearing no objection, so ordered.

[The prepared statment of Chairman Mario Biaggi follows:]

PREPARED STATEMENT OF CHAIRMAN MARIO BIAGGI

This hearing today is convened to examine the longterm care ombudsman program in the occasion of its decade of service to the institutionalized elderly.

For the 1.4 million institutionalized elderly, this program is often the one avenue they possess to assure that their needs and concerns are addressed—that they are provided quality care—and that they are afforded full rights and privileges under law.

This program, authorized under the Older Americans Act Amendments of 1976, must be more aggressive, independent and visible in order to achieve its mandate of protecting the rights of elderly nursing home residents. To begin with—budgets for this program—by law 1% or $20,000 of a state's allocation under the Older Americans Act—are insufficient to meet need.

The total amount of federal dollars being spent on this program—$12 million—means that we are spending about $1 per long-term care resident per year. For a program that is vital to the health and well-being of this population—$1 per persons is an inadequate amount.

Secondly, states develop programs in patchwork fashion. There is no program standardization. Only 50 per cent of the programs operate within the state agency directed tolicense and certify nursing homes. If the program is to be independent and have an impact—this arrangement must be changed. Reporting to state agencies that do not have the direct ability to suspend or revoke a license is unnecessary bureaucracy.

Finally, the program fails to cover a number of alternative care situations—such as home care programs. The 1984 amendments to the Act required ombudsman to monitor board and care facilities. However, home care programs—which have grown in size and scope—are still not covered.

The Subcommittee will receive testimony today from a number of distinguished witnesses that have been historically involved with this program. We are proud to have the "father" of this program—former AoA Commissioner Arthur Flemming—provide us with his insights into the role anticipated for this program when it was first created.

We will also hear from the Administration on Aging on how they have overseen this program. We are anxious to learn of their future plans to provide resources and technical support to state ombudsman programs. Given the mixed reviews this program has received, we are anxious to hear of their current and ongong efforts in this area.

We will also hear from residents in facilities who will share with us their own personnel experiences. Finally, we will hear from a number of ombudsman that will provide us with important information on the variety of programs that currently operate within states and make recommendations for program improvement.

I thank the witneesses for their testimony and look forward to their comments.

Mr. WYDEN. Let me say right at the outset that we are pressed for time this morning. I'm going to ask that all witnesses limit their comments to 5 minutes. We will make a part of our prepared hearing record the comments in their entirety. But if we're going to finish this morning and give an opportunity for all our witnesses to state their views and have some time for questions, we're going to have to adhere to that time limit.

Mr. Suzuki, we're very happy that you could join us here today. As I said, we will make a copy of your prepared remarks a part of the record. If you could summarize in 5 minutes your principal concerns that will be helpful, and we'll have some time for questions. Welcome.

STATEMENT OF MICHIO SUZUKI, ASSOCIATE COMMISSIONER, OFFICE OF STATE AND TRIBAL PROGRAMS, ADMINISTRATION ON AGING

Mr. SUZUKI. Thank you, Mr. Chairman. My name is Michio Suzuki. I am the Associate Commissioner for State and Tribal Programs, Administration on Aging, and I am responsible for the Federal oversight of the Ombudsman Program, which is part of the State program of aging services authorized under the title III of the Older Americans Act. Carol Fraser Fisk, Acting Commissioner on Aging, has asked me to express to you and members of the subcommittee her regret that she is unable to be present for this hearing because of an out-of-State speaking commitment. We thank you for affording the Administration on Aging the opportunity to present the following testimony on the Long-Term-Care Ombudsman Program.

States are required under section 307(a)(12) of the Older Americans Act to establish and operate Long-Term-Care Ombudsman Program. The States may operate the program directly, or by contract, or arrangement with any public or nonprofit organization other than the one responsible for licensing long-term care facilities in this State.

Mr. Chairman, since the written testimony was submitted, the numbers of the location of the units have been clarified. Of the 54 State and territorial Ombudsman Programs, 41 are directly operated by the State unit on aging, and 13 have programs which are operated outside of the State unit on aging.

The functions of the Ombudsman Program include investigation and resolution of complaints made by residents of long-term care facilities, establishing procedures for ombudsman access to facilities and patient record, establishing a statewide reporting system to collect and analyze data relating to complaints, and establishing procedures to assure client confidentiality.

The Ombudsman Programs are required to monitor the development and implementation of Federal, State, and local regulations and policies with respect to long-term care in the State. They also provide information to public agencies regarding the problems of older people in long-term care facilities. In addition to their work on investigating individual complaints, State Ombudsman Programs engage in a wide variety of activities related to program development. These activities fall into the following categories.

Ongoing development and support of substate Ombudsman Programs with developing contracts, agreements, with sponsoring organizations; providing basic ombudsman educational materials; training and certifying staff and volunteers; and maintaining a statewide network of newsletters and meetings of local program directors.

Publicizing the program in long-term care issues through the production and dissemination of consumer information publications, such as residents' rights booklets, rights to nursing home brochures and posters on the program, and appearances on the media.

I'll skip some of this material, just to say that the ombudsmen have a great impact in helping improve the long-term care system by identifying problems which affect large numbers of older people. They often affect changes in policies, procedures, regulations, and legislation to alleviate or resolve these problems.

While the Older Americans Act provides a legislative base for all State ombudsman activities, a growing number of States have strengthened their programs through enactment of State statutes which provides specific State authorities for the program. Twenty-six States have enacted such ombudsman legislation.

Nationwide over 1,000 paid staff, and more than 5,000 volunteers, work in the Long-Term-Care Ombudsman Program to investigate complaints, monitor regulations, provide information on ombudsman related issues, and provide for staff and volunteer training. The 1984 amendments to the Older Americans Act added the requirement that each State provide an individual on a full-time basis to carry on these responsibilities. Prior to 1984 there was no such requirement for full-time staff positions.

The Older Americans Act requires each State to use an amount for Ombudsman Program purposes equal to the greater of $20,000, or 1 percent of its title III allotment for supportive services, 3(b). The requirement for using title III funds does not apply in the fiscal year in which the State spends the required amounts from State or local sources. It should be highlighted that there is no limitation by statute on the amount of Older Americans Act funds that may be expended on ombudsman activities over the minimums required. States are free to allocate in amounts which best support State and local priorities for Ombudsman Programs.

In fiscal year 1983 a total of $12,100,000 Federal and non-Federal dollars were expended on ombudsman activities at State and substate levels; $8.9 million were Federal funds, and $3.2 million were non-Federal. From fiscal year 1979 to 1984 grants were made available to State units to assist them in establishing their Long-Term Care Ombudsman and Legal Services Program. The amounts expended annually on that program was approximately $2.8 million. These grants were made under title IV of the Older Americans Act. States used funds under these grants to develop objectives, broaden local programs, secure State ombudsman legislation, and coordinate ombudsman and protective services.

So the activities connected under these grants were assisting ombudsman in investigation of nursing home complaints, providing training in TA, and implementing substate programs, and coordinating the Ombudsman Program with other State agency activities.

Mr. Wyden. Mr. Suzuki, excuse me. I've let you go a little bit over 5 minutes.

Mr. Suzuki. OK.

Mr. Wyden. If you could summarize.

Mr. Suzuki. All right. What I would just like to perhaps do then is just pick a couple of numbers out of the submitted testimony that indicates the growth of the program. We have data for 40 States for fiscal year 1982 and 1984, and I would point out that the total funding from all sources from State-level programs was $3,119,897 in 1982, $3,839,000 in 1984. The point being that there was a 23-percent increase in State activity level funding. Again, the number of complaints between fiscal year 1982 and 1984 went from 29,000 to 46,000, again an increase of 56 percent in terms of total number of complaints filed.

And then again from the sample of 40 States, just to illustrate the growth, we have 330 substate programs in those 40 States which grew to 399 in 1984, or an increase of 21 percent.

Quickly I will just highlight some of the things that we have done from the Administration on Aging to support the program. We have distributed to the States and local programs, a 21-chapter technical assistance manual which was completed over several years, drawing upon the efforts of many people in the field. In November 1984 in Philadelphia we had a national ombudsman conference, in which we had 151 people participating.

There are a number of other activities by which we support the program. We had over eight regional meetings since the November conference sponsored by regional offices. We have had a fairly aggressive program in supporting the development of the Ombudsman Program in the States.

We believe the Ombudsman Program has proven to be active in serving the needs of older residents of long-term-care facilities. As for program expansion and further development, let me emphasize again, there's a minimum expenditure required under the law, but is up to the State in terms of the nature and breadth of the program.

This concludes my remarks. I'm sorry it took a little longer, but I will be pleased to try to answer any questions that you may have.

[The prepaired statement of Mr. Suzuki follows:]

PREPARED STATEMENT OF MICHIO SUZUKI, ASSOCIATE COMMISSIONER, OFFICE OF STATE AND TRIBAL PROGRAMS, ADMINISTRATION ON AGING

INTRODUCTION

My name is Michio Suzuki—I am the Associate Commissioner for State and Tribal Programs, Administration on Aging, and am responsible for the Ombudsman Program which is part of the State program of aging services authorized under Title III of the Older Americans Act. Carol Fraser Fisk, Acting Commissioner on Aging has asked me to express to you her regret that she is unable to be present for this hearing, because of an out-of-state speaking commitment. Thank you for affording the Administration on Aging the opportunity to present the following testimony on the long-term Care Ombudsman Program.

States are required under Section 307(A)(12) of the Older Americans Act to establish and operate Long-Term Care Ombudsman Programs. The State may operate the program directly, or by contract or other arrangement with any public or non-profit organization other than one responsible for licensing long-term care services in the State. In forty-three states, the State Agency on Aging administers the program. In eleven states and the District of Columbia, the program is operated by an agency other than the State Agency on Aging.

The functions of an ombudsman program include the investigation and resolution of complaints made by residents of long term care facilities, establishing procedures for ombudsman access to facilities and patients' records, establishing a statewide reporting system to collect any analyze data relating to compliants, and establishing procedures to assure client confidentiality.

The ombudsman programs are required to monitor the development and implementation of Federal, State and local laws, regulations and polices with respect to long-term care in the State. They also provide information to pubic agencies regarding the problems of older people in long-term care facilities. In addition to their work on investigating individual complaints, state ombudsman programs engage in a wide variety of activities related to program development. These activities fall into the following categories.

Ongoing development and support of sub-state ombudsman programs through developing contracts and agreements with sponsoring organizations; providing basic ombudsman informational materials; training and certifying staff and volunteers; and maintaining a statewide network by newsletters and meetings of local program directors;

Publicizing the program and long-term care issues through the production and dissemination of consumer information publications, such as residents' rights booklets, guides to nursing homes, brochures and posters on the program, and ombudsman appearances on the media;

Serving on boards, committees and task forces dealing with long-term care issues;

Monitoring the development and implementation of Federal, State and local legislation and regulations pertaining to long-term care facilities in that state, and;

Promoting the development of residents' councils and community councils for long-term facilities and providing training and technical assistance for council members.

Ombudsmen often have a great impact in helping to improve the long-term care system by identifying problems which affect large numbers of older people. They often effect changes in policies, procedures, regulations, and legislation to alleviate or resolve those problems.

While the Older Americans Act provides a legislative basis for all State ombudsman activities, a growing of States have strengthened their programs through enactment of State statutes which provide specific State authorities for the programs. Twenty-six States have enacted ombudsman legislation.

Nationwide, over 1,000 paid staff and more than 5,000 volunteers work in the Long-Term Care Ombudsman program to investigate complaints, monitor regulations, provide information on ombudsman-related issues and provide for staff and volunteer training. The 1984 Amendments to the Older Americans Act added a requirement that each State provide an individual on a full-time basis to carry on these responsibilities. Prior to 1984, there was no requirement for a full-time staff position.

The Older Americans Act requires each State to use an amount for Ombudsman purposes equal to the greater of $20,000 or 1% of its Title III allotment for supportive services. The requirement for using Title III funds does not apply in a fiscal year in which a State spends the required amounts from State or local sources. It should be highlighted that there is no limitation on the amount of Older Americans Act funds that may be expended on Ombudsman activities over the minimum amounts required. States are free to allocate funds in amounts which best support State and local priorities and for ombudsman programs.

In FY 1983 a total of $12.1 million Federal and non-Federal dollars were expended on ombudsmen activities in state and sub-state programs: $8.9 million were Federal funds, and $3.2 million were non-Federal. From FY 1979 to FY 1984, grants were made available to State Units on Aging to assist them in establishing their long-term care ombudsman and legal services programs. The amount expended annually was approximately $2.8 million. These grants were made under Title IV of the Older Americans Act. States used funds under these grants to develop objectives, broaden local programs, secure State ombudsman legislation, and coordinate ombudsman and protective services.

Some of the activities conducted under these grants were: assisting State ombudsmen in investigating nursing home complaints; providing training and technical assistance in implementing substate programs; and coordinating the ombudsman program with other State agency activities.

Beginning in FY 1985, AoA instituted the new formula for State administration based upon the 1984 Amendments to the Older Americans Act. Under this formula, which enables States to expend up to five percent (5%) or $300,000, whichever is greater, of its Title III appropriation for administration. Funds are expended for the State Ombudsman Program, State training, and other administrative costs.

PROGRAM GROWTH

I would like to present an indication of program growth, even though our 1984 data are incomplete. The Administration on Aging is in the process of computerizing and confirming data for the 1982-84 period.

On three measures of program growth—amount of funding, the number of complaints, and the number of sub-state programs—we have comparative data from 40 states for FY 1982 and FY 1984. Data in these states appear complete and accurate.

We expect to have data for all states and further information on other aspects of the program prepared in a full report by December of this year.

In these 40 states:

(1) The total funding from all sources for state level programs increased from $3,119,897 in FY 1982 to $3,839,284 in FY 1984, an increase of $719,387, or 23%. Of the forty states, 30 had increased their resources, 8 decreased, and 2 remained the same.

(2) The total number of complaints filed statewide in these 40 states increased from 29,699 in FY 1982 to 46,325 in FY 1984, an increase of 16,626 or 56%. The number of complaints increased in 34 states and decreased in 6 states.

(3) In this group of states, the number of sub-state programs grew from 330 in FY 1982 to 399 in FY 1984, an increase of 69 or 21%. The number of sub-state programs increased in 17 states, decreased in 10 states, and remained the same in 13.

ADMINISTRATION ON AGING SUPPORT TO THE OMBUDSMAN PROGRAM

The Administration on Aging has undertaking various activities to provide technical assistance and support to the ombudsman program. The Office of State and Tribal Programs is responsible for the overall administration of the program. Under my direction, two divisions, the Division of Operations and Financial Analysis and the Division of Program Management and Regional Operations execute various aspects of the program.

Each Regional Program Director of the Administration on Aging has designated a staff person to serve as a specialist with regard to ombudsman programs.

To assist the States in further development and refinement of their programs, the Administration on aging has provided technical assistance to State and substate ombudsman programs through issuance of a comprehensive manual. The manual is based on "best practice" of State and local programs, as identified by staff members of the former Bi-regional Resource and Support Centers, the National Citizens Coalition for Nursing Home Reform, the National Senior Citizens Law Center, and AoA staff. The twenty-one chapters include training of ombudsmen staff and volunteers, complaint documentation, consent forms, the role of volunteers, sample job descriptions, and fundraising.

In November of 1984, a national ombudsman conference conducted by the Administration on Aging was held in Philadelphia. There were 151 attendees including directors of State Aging Agencies, State Ombudsmen, Regional and Washington AoA staff, and other agency representatives working in conjunction with ombudsman programs. Eight AoA Regional Offices and about twelve States have held follow up conferences.

We believe the ombudsman program has proven to be effective in serving the needs of older residents of long-term care facilities. Program expansion and further development of the role of the State ombudsman is a planning option individual States may wish to explore.

Mr. Chairman, this concludes my prepared remarks. I will be pleased to discuss any aspects of the ombudsman program and will be happy to respond to questions which you or any of the other subcommittee members may have.

Mr. **Wyden**. Thank you very much, Mr. Suzuki. I just have a couple of questions, and then I'm going to yield to my colleagues.

It's been a little hard for the subcommittee to track the progress of the program as the Administration on Aging has not submitted the compilation of the State reports for 2 years now. We understand that a report will be available in December of this year. My question to you is why has it taken almost 3 years to get a full report on this program?

Mr. **Suzuki**. Well, the last report was for fiscal year 1982, which was published in 1983.

One of the problems that we have is that there is not a required format. There's a recommended format and what we have is individual State's reports. If you're looking at a single State it's fairly descriptive. But it's very difficult to aggregate these figures nationally. We have now gone to a computerization of the data with an effort to encourage the States to adopt uniform definitions so that there is a possibility of aggregating.

This uniformity has been very difficult to achieve. Even in the 1982 report you'll find many references to a sample of 5 States, or a sample of 10 States. We just can't get the 54 jurisdictions reporting the same data. We are trying.

Mr. **Wyden**. But the Administration has had already the authority to require a uniform system for getting this information. I'm concerned about why the Administration hasn't used that existing authority so that we could get this information in a usable form.

Mr. **Suzuki**. We lay out the format that we recommend and want. What happens is that the States, in filling the report form out, don't answer the question as presented. They will give other figures that are slightly off. We recognize that we need more efforts in trying to develop uniformity. We hope with the computerization of the data to sharpen our ability to analyze and spot the places where the data has been ambiguous or weak. We hope that the publication of the reports will be more regular and more timely.

Mr. WYDEN. I have only one other question. It's my understanding that a number of States still do not have an Ombudsman Program; is that correct?

Mr. SUZUKI. That is not correct, sir. There is legal requirement that there be a full-time ombudsman in every State in the Union. As of the last count that I have, there is a full-time position established in all the States.

Mr. WYDEN. Arkansas, Virginia, Texas, and Montana were the ones that I had a question about. They all have programs in full-swing now?

Mr. SUZUKI. Arkansas, I understand, has an ombudsman, and Virginia's State director is here today to testify. They have an Ombudsman Program. I do know that in Pennsylvania there is a full-time position which has recently become vacant. But the best information I have is that all of the positions that are required by statute for a full-time position are in place.

Now, there are some States which do not have substate programs.

Mr. WYDEN. Doesn't the law require that too?

Mr. SUZUKI. It has a requirement that it cover the State, but it can be a mechanism administered by the State system, and not dependent on the local system.

Mr. WYDEN. I want to recognize my colleague. Thank you, Mr. Suzuki.

Ms. SNOWE. Thank you, Mr. Chairman.

Mr. Suzuki, to your knowledge, are most ombudsmen full-time ombudsmen, or do others assume additional responsibilities over and above the ombudsman responsibilities?

Mr. SUZUKI. Under the 1984 amendment, States are required to have a full-time ombudsman.

Now, as I reported earlier, there are 1,000 staff members. Many of them are part-time, any others are full-time. The one ombudsman per State is required since the 1984 amendments to be a full-time staff member.

Ms. SNOWE. As you know, the 1984 Older Americans Act amendments mandated training for the staff, as well as for volunteers in the Ombudsman Program. How would you define training, and what has been the Administration's role in the training of staff in these programs? And are there Federal minimum requirements for such training? As you know, in the past some nursing home operators have complained that many of the ombudsmen have not been adequately trained to assume their responsibilities.

Mr. SUZUKI. Clearly the States make a commitment in their State plan that they will undertake that training. Resources are made available from the Older Americans Act Federal funds to support the administrative cost for such training. We recognize there's a need for additional training supported at the Federal level. We consider activities such as the national ombudsman conference and the meetings held by our regional staff as part of the training effort.

But we feel essentially the responsibility for training of State and local staff, it rests with the States. We certainly will make resources available. We encourage and stimulate training through technical assistance such as the volume on best practices that we have made available to States.

We are also issuing a State self-assessment guide which States will be free to use to pinpoint where there are inadequacies in the State program.

We were asking questions about the adequacy of training. When you think about 1,000 staff members and 5,000 volunteers, I would make *no claim that we have achieved adequate training of all* those people. I think we need to continue pressing on.

Ms. Snowe. But does the Administration on Aging know which staff, or which volunteers, have not been trained in the various States?

Mr. Suzuki. During the current year we have had some reviews of State programs by our regional staff. Again, trying to identify those States where there may be more effort needed.

But training is not only required for ombudsman, but for all of the staffs that are involved in aging service programs.

I think we have recognized the special concern for training in Ombudsman Programs. More needs to be done. We're having a number of regional meetings encouraging States to strengthen their program.

Ms. Snowe. Does the Administration serve as a clearinghouse in any sense? By that, I mean if the State has a particular problem can it come to the Administration on Aging to find out what other States are doing to resolve that problem?

Mr. Suzuki. Many of the regional meetings serve that purpose. For instance in Chicago in November. The six States in the Midwest regions will come together, and the agenda for that conference is developed by the States, as well as by our regional office. There is an attempt at those regional meetings to offer an opportunity for technology transfer, to exchange information. And certainly the State programs contact our regional office for assistance. They may have within their own region, or they will check with us in central office, and we will try to get materials from other States. And there are other organizations which offer some of this assistance.

We do not have a formal clearinghouse as such, but we try through our Federal staff connections to make information available.

Ms. Snowe. Getting back to the training, as I understand it, there were grants that were made up until 1981 for training purposes that were terminated. What was the reason for that termination, and is there any inclination on the part of the administration to resume those training grants?

Mr. Suzuki. If you're talking about the title IV grants for Ombudsman Programs, they were given from 1979 through 1984. Under the 1984 amendments, starting in 1985 there was no separate amount for administration. We had to identify all amounts that we had made available in 1984 to the States for administrative type expenditures as a base figure. Under the law $300,000 or 5 percent of the title III funds we made available can be used for administration. If that amount was less than we gave to the State in 1984, including the ombudsman grant, we then had to supplement.

Actually for the year 1985 more funds were made available in support of administrative activities, including support to the Ombudsman Program than had been given earlier.

Ms. SNOWE. Does the amount that you just referred to, the 5 percent, have anything to do with training?

Mr. SUZUKI. Yes, administration covers training. They can use such funds for training,

Ms. SNOWE. I see. But there's no specific amount allocated?

Mr. SUZUKI. No. And under the earlier grants their was no specific amount for training. As indicated in the written testimony, they could be used for training, but also for development, recruitment, and other activities.

Ms. SNOWE. Thank you, Mr. Suzuki. Thank you, Mr. Chairman.

Mr. WYDEN. The gentlemen from Oklahoma.

Mr. SYNAR. Thank you very much.

Before I go onto my question—and I only have one question—I think the line of questioning pursued by Congresswoman Snowe is really where the rubber meets the road. I think the major complaint that we hear when we're out in our congressional districts is that we have some training problems, and personnel problems. I think that that's something that we need to look into with great interest.

The other place that we have a major concern is that area of funding.

Mr. Suzuki, on page 7 of your testimony you said the total number of complaints filed statewide in these 40 States increased from 29,699 in fiscal year 1982 to 46,325 in fiscal year 1984. That's an increase of 56 percent on the number of complaints that we're getting.

Yet, if my facts serve me right, in the 10 years that this program has been in existence, OMB, and the Administration on Aging, have not increased the minimum level of Government involvement in the program. Is that correct?

Mr. SUZUKI. I'm not sure what you mean by the Government involvement, but as far as the——

Mr. SYNAR. Federal Government involvement.

Mr. SUZUKI. As far as the amount of resources that have to be available, there is a minimum stated in the law.

Mr. SYNAR. But we've never gone above that minmum, have we?

Mr. SUZUKI. It is a minimum, and at State option they can go far above.

Mr. SYNAR. I didn't ask you that. We have never made our Federal contribution above the minimum.

Mr. SUZUKI. Well, States draw more than the minimum. Thirty States of the 50 jurisdictions draw more than 1 percent of 3(d) for the Ombudsman Program. Many States spend many times the minimum.

Mr. SYNAR. But the floor has never been raised, has it?

Mr. SUZUKI. No, the floor has never been raised, and, you know, again let me say that it is a floor. It authorizes the State to spend funds in terms of its needs and its priorities. Every State has to have an ombudsman program.

Thirty States exceed the minimum 1 percent expenditure just out of 3(b). That's not even counting the funds that come from non-Federal sources.

The program is growing in terms of total support over the years.

Mr. **Synar**. Will you support increased minimum support, raising the floor?

Mr. **Suzuki**. I can't speak for the administration on that point. I haven't heard any discussion, but I think our position would be that it is a minimum and gives the States authority to exceed. And, as I say, many States exceed that minimum. It's a question of where the priorities should be in any given State with the resources that are available.

Mr. **Synar**. Let me ask you another thing, Mr. Suzuki. Are you familiar with the letter we sent Mr. Stockman on June 20, 1985 with respect to the OMB Circular A-122, and how it applies to the Older Americans Act?

Mr. **Suzuki**. By that identification I do not.

Mr. **Synar**. Fifty Congressmen signed this letter. Let me have staff outline what this is. Then I'll have a question for you.

Mr. **Suzuki**. OK.

Ms. **Synar**. Under the letter that we sent to Mr. Stockman asking for clarification of the adequacy provisions of the Older Americans Act, upon A-122 and what the plans of the Office of Management and Budget were with respect to the 1984 proposed regulations to the act, and whether or not they plan to make the provisions of A-122 and the restrictions on advocacy by receipt of federal funds applicable to the Older Americans Act.

Last year the subcommittee wrote to the Office of Management and Budget when they were revising the A-122 circular, and asked if they planned to apply A-122 to the Older Americans Act, and at that time they said no.

We had subsequent information that given the 1984 amendments last year that they were planning to revise the circular and make it apply. And the concern deals with the Ombudsman Program within the Older Americans Act.

Mr. **Suzuki**. I am aware of the issue, sir, about the advocacy issue. I have discussed the issue with the policy staff. I do know they have been examining that issue, and there was a great deal of work on that. But I was not participating in——

Mr. **Synar**. But what factor of their decision on that?

Mr. **Suzuki**. Let me be very frank. I think the decision was made. I will check it out.

Mr. **Synar**. Regulations haven't been published in final form, right?

Mr. **Suzuki**. The regulations are published as interim form. There was a period of comment, and I think the final regulation will then be issued.

Mr. **Synar**. OK, thank you very much. Thank you, Mr. Chairman.

Mr. **Wyden**. I thank the gentleman from Oklahoma. Just one other question very quickly, Mr. Suzuki.

Does the administration support extending the Ombudsman Program to home health care agencies? I think we see a tremendous growth of activity in the home health care field, and the subcommittee would be interested in the administration's position about whether the concept ought to be extended to home health programs.

Mr. **Suzuki**. I think there has been no formal position adopted. The issue has been raised. One of the concerns is that the Ombudsman Program has been effective but still underdeveloped. It has been growing from nursing home care, to all long-term care residential facilities. There are advocates who say there should be Ombudsman Program relative to all things that happen for the elderly. I think there is some question on our part whether we need to develop even further the Ombudsman Program relative to the long-term care facilities before it should be made available across the board. It would be a large undertaking. I don't think we've reached a full maturation of the Ombudsman Program relative to long-term care.

Mr. **Wyden**. Are you developing a policy to do that, to extend this program?

Mr. **Suzuki**. The issue was raised as we planned the ombudsman conference. Some national organizations have advocated that the ombudsman concept should be extended to all kinds of services.

At this point in time we haven't said yea or nay. We have been looking at it, and I think the direction I would take is to strengthen the program that we have. The undertaking in terms of a whole range is quite a task.

There is the fear of a dilution of what we have now.

Mr. **Wyden**. Well, we thank you for your time today, Mr. Suzuki, and I know we'll be in touch with you in the days ahead. Thank you.

Mr. **Suzuki**. OK. Thank you very much.

Mr. **Wyden**. Our next panel, Charlotte Rosenfield, daughter-in-law of a resident in Montgomery County, MD, long-term care facility, and Janet Tulloch, a resident in Washington, DC long-term care facility who is the author of a truly superb book, in my view, "A Home is Not a Home."

If our witnesses will come forward. We look forward to your testimony.

We're also very pleased to have a colleague from Arkansas, Mr. Robinson, here, and if he would like to make any comment while our witnesses are coming forward we welcome his views.

Mr. **Robinson**. Mr. Chairman, I would just like to ask unanimous consent to submit for the record a written statement. I would thank you for holding this very important hearing today.

Mr. **Wyden**. Without objection, your statement in its entirety will be entered into the record.

[The prepared statement of Mr. Robinson follows:]

PREPARED STATEMENT OF REPRESENTATIVE TOMMY F. ROBINSON

Mr. Chairman, I am very pleased that you have called today's hearing. Issues surrounding long-term care for this nation's elderly population rank among the most troubling and the most troublesome.

Statistics abound on the "graying of America." The over-65 age group comprises the fastest growing segment of our population. In addition, the growth in the numbers of frail elderly is astounding. In any given year, many of these senior citizens will spend time in a long-term care facility—20% of the elderly will enter a nursing home at some point in their lives.

Many of these elderly are alone—finding themselves without the support of spouses, friends or nearby relatives. Until the Ombudsman Program was instituted 10 years ago under the Older Americans Act, these elderly had no voice, no recourse when victimized by those ostensibly caring for them. Overmedication, neglect, inadequate attention to diet requirements, physical and sexual abuse were horrors to which some nursing home residents were subjected.

The Ombudsman program has made great strides in erasing these occurrences of neglect and abuse. In reviewing advanced copies of the testimony we will receive today, I am pleased with the overall success of this too-little-known program.

I am interested in hearing how—notwithstanding the constraints of gigantic budget deficits—this long-term care ombudsman program can be expanded. How can we do a better job of letting people know what the Ombudsman's function is?

I have a loved one in a nursing home. She has family and friends close to monitor her care and her spirits, to insure that her needs are being net. She is among the fortunate. The elderly who live where there is an active vital Ombudsman program are also among the fortunate. We must make sure that this umbrella of protection is extended to all our senior citizens who are in long-term care facilities.

Mr. Wyden. We thank our witnesses for their appearances today. Why don't we begin with you, Ms. Rosenfield. We will make a copy of your prepared remarks a part of our hearing record. If you can summarize in 5 minutes your views that will leave plenty of time for some questions.

Ms. Rosenfield. Thank you.

STATEMENT OF CHARLOTTE ROSENFIELD, DAUGHTER-IN-LAW OF RESIDENT IN A MONTGOMERY COUNTY, MD, LONG-TERM CARE FACILITY

Ms. Rosenfield. Mr. Chairman, and members of the committee, I want to thank you for inviting me here today.

I have the distinct opportunity of witnessing the Long-Term-Care Ombudsman Program in action due to a crisis that arose in the life of my husband's mother, Ida Spivock, who has been a resident of a nursing facility in Montgomery County, MD, these past 4½ years.

Mother Spivock is an invalid who is confined to a wheelchair due to disabling arthritis, poor vision, plus a multitude of other ailments. Despite these problems, she is very independent and tries to do things for herself as much as possible. Her mind is clear, and her memory good for a lady of her years.

I was totally unaware that she had become a victim of overmedication by the sheer neglect of her doctor who prescribed sedatives on a remote control basis. In this instance it was the drug Haldol. I've since been told that it is often given to long-term care patients to keep them sedated. In the case of Mother Spivock, this drug had a devastating effect. I was called by the nursing home and alerted to the fact that she had a serious behavior problem which was affecting other patients, as well as the staff, and that she was totally confused. They continued that she would be moved to the locked ward of the home where patients suffering from advanced senility were stationed. In desperation I called her doctor for help. He, in turn, called the nursing home and instructed them to increase the dosage of the drug. Little did I know just why her behavior worsened.

It was at this point that I called upon the Long-Term-Care Ombudsman Program for help because of prior knowledge I had of them from past experience. Within 1½ hours after a call was placed for assistance their director arrived at the nursing home.

She first visited Mother Spivock and noticed at once that she was heavily drugged. She and I retired to the administrator of the nursing home's office where we were joined by the director of nursing and their social service worker. The ombudsman representative held her ground in defense of mother, and at no time lost her cool. One and one half hours later the results of the meeting were that Mother Spivock would remain in her quarters for an additional 5 days to see if her condition would change. A psychiatrist would be called in immediately to examine and evaluate mother.

That evening a volunteer ombudsman stood by mother's wing to watch and see how things were going. The following morning she returned and continued her watch. That afternoon the ombudsman director stood vigil in the wing. The psychiatrist arrived and examined Mother Spivock. He found her to be overmedicated from the Haldol, gave her a clean bill of mental health, and left instructions for all sedation to be discontinued at once.

The next day the ombudsman director visited the nursing home once again. She then had a meeting with the director of nursing. She received an immediate reprieve for Mother Spivock. She said that as long as her behavior remained proper Mother Spivock would remain in her present surroundings.

Several days later the director of nursing of the home got a letter from the Long-Term-Care Ombudsman Program confirming their final conversation with regards to Mother Spivock. The letter also stated that it was agreed that in the event of a change in Mother Spivock's behavior and they wanted to transfer her, that the Ombudsman Program would be notified at once. This incident took place 6 months ago. Mother is her happy self at this time, as we all are.

Mr. **Wyden**. Thank you very much, Ms. Rosenfield.

We're very pleased to have Ms. Tulloch, and as I understand it, the ombudsman person from her area—both of you with us. We are just delighted that you could join us. However you all would like to proceed. We're just pleased that you're here.

STATEMENT OF JANET TULLOCH, RESIDENT IN A WASHINGTON, DC, LONG-TERM CARE FACILITY, AUTHOR OF "A HOME IS NOT A HOME"

Ms. **Tulloch**. The era of blatant neglect and abuse of nursing home residents has been obliterated through Federal and State regulatory systems. Now, vulnerability is reached through more subtle forms of psychological harrassment. Only qualified ombudsmen, endowed with legalized authority, can monitor and help correct such situations.

These are instances of intervention by the Ombudsman Program, I have witnessed:

The time between dinner and breakfast is not allowed to exceed 14 hours according to regulations. In my facility this regulation was often violated in the past. Since I am an early riser, I would like to have my first meal on time, before 8:30 in the morning, especially because my last meal was a cold-plate supper at 5:30 the previous evening. Through negotiation and close monitoring by the Ombudsman Program this problem has been almost eliminated.

Laws give residents freedom to smoke in specified areas of the facility. Each facility develops its individual smoking policy. In my home an individual is not allowed to have matches or lighters in their room. This means that if they choose to have a cigarette, they must either call for a nurse and wait and wait, or, they must go to the nurses' station, if able, and try to find a nurse to light their cigarette. While I am strongly opposed to anyone, anywhere, smoking for health purposes, my feelings run even more deeply when responsible persons cannot possess a lighter or a match. Such breaches of personal trust and dignity fosters anger, resentment, and disobedience.

The ombudsman has effectively negotiated on behalf of several residents to maintain their dignity while still keeping them safe. For example, one resident had been caught smoking. The ombudsman intervened on her behalf. She now goes to a nearby porch to smoke. This allows a responsible resident to maintain her dignity and independence.

A strong Ombudsman Program protects residents' rights. The ombudsman assists in monitoring other real and potential problems that residents help identify such as a shortage of nursing staff and discrimination against residents on Medicaid. Ombudsmen are the community support which assures the institutionalized elderly and the disabled the highest quality of care.

Mr. **Wyden**. Thank you very, very much, Ms. Tulloch, for an excellent presentation, and, Ms. Rosenfield, to you as well. Just a couple of questions I'd like for each of you to answer.

Ms. Tulloch, do you think that nursing home residents are now aware enough of the Ombudsman Program so that they know that they can use it to prevent harassment?

Ms. **Tulloch**. They are required to place a poster in a prominent place in the home. Resident counsel have ombudsman in attendance.

Mr. **Wyden**. Well, that's a very good answer, and I appreciate your describing the sign, and saying that there are people available trying to get the word out. I think part of the problem often isn't Social Services. It's just very hard to get the word to those who need it the most. And because of your courage, your fine book, and your presentation, it's going to be a little bit easier for us to get the word out about this program. I very much appreciate your being here.

Just one question for you, Ms. Rosenfield. The account that you've given us essentially gives us an example of how the program works, how it essentially works for you and Ms. Spivock.

How did you know who to call? Had you seen one of the signs, or had someone told you about them? I'm just kind of curious how you found out about the system and used it to make it work for your family.

Ms. **Rosenfield**. On many occasions my mother-in-law referred to a wonderful Government worker that would come in and visit her, and was so kind, and was so understanding of her problems. In one particular case—she's in a wheelchair at all times, and very independent when she has to use bathroom facilities. She was having difficulty getting through the door. The room actually wasn't large enough. Because of this problem they were going to move her downstairs. She is bright enough, and aware enough, that because she's arthritic the dampness downstairs causes her many problems. The ombudsman came in and took care of this problem. They moved the bed, got her special permission, and the problem was resolved.

However, at that time in talking with them—I'd never met them personally, but I had spoken with them on the phone—I was told that at any time that my mother-in-law had a problem of any kind to not wait but to call immediately, and this I did.

Mr. **Wyden.** Well, very good. Let me recognize my colleague from Maine.

Ms. **Snowe.** Thank you, Mr. Chairman. I want to thank Ms. Tulloch and Ms. Rosenfield for your outstanding testimony in every respect, and the contribution that you have made here today.

Ms. Tulloch, I have a question for you first. In your testimony you mentioned in the first paragraph that only qualified ombudsmen endowed with legalized authority can monitor and help correct such situations. Could you further clarify that statement? Are you referring to the fact that some States have legislation that gives access to ombudsmen to nursing homes, and to residences. Is that what you're talking about?

Ms. **Tulloch.** Ombudsmen need a credibility, the authority to do the job. Nursing homes need to accept these credentials.

Ms. **Snowe.** Do you think that nursing homes have established procedures—ways in which to work with ombudsmen.

Ms. **Tulloch.** We're only beginning.

Ms. **Snowe.** You're only beginning to do that.

Ms. **Tulloch.** Yes.

Ms. **Snowe.** So we need to do more of that with respect, to nursing homes?

Ms. **Tulloch.** Yes.

Ms. **Snowe.** Would you say that nursing homes and ombudsmen for the most part still have an adversarial relationship, or is that waning and becoming more of a working relationship?

Ms. **Tulloch.** Many times an ombudsmen becomes in the adversarial role which is almost a necessity, but as staff learn they are helping the total community by acting as advantegeous intermediary, staff, resident, and ombudsmen work together.

Ms. **Snowe.** Thank you.

Ms. Rosenfield, you mentioned earlier your mother-in-law's awareness of a good Government worker coming into the nursing home. Is it your opinion that other residents of the nursing home also are aware that there's an ombudsman? Do they clearly understand the role of the ombudsman, and were notices posted in your mother-in-law's nursing home?

Ms. **Rosenfield.** I can't really say I noticed anything posted. However, I am almost certain that the—this ombudsman worker, visited not only my mother-in-law, but many of these people in that wing, and probably the whole nursing home for those that required it.

She is a very, very dedicated and a wonderful woman. She takes a tremendous interest in all the problems that these people face, and, believe me, there's many of them.

Ms. **Snowe**. What was your assessment of the relationship between the ombudsman and the nursing home?

Ms. **Rosenfield**. I've never seen it in action actually, but——

Ms. **Snowe**. In your particular instance.

Ms. **Rosenfield**. I think as soon as I called and the director of the ombudsman arrived, they all stopped and took notice because they had me on the hot plate for at least 2 hours, maybe an hour and a half before she came. And the administrator said, "Well, if you don't like it here you can find another nursing home. She will be moved." That's when I knew that there was a problem, but I wasn't going to swallow that. It wasn't until our wonderful director of the ombudsman arrived, and she handled it in such a way that you can't believe, without creating any waves. It was just smooth. And she listened. She knew just what to say, and when to say it, with a wonderful result. I mean, they refused to give me any extended time. Mother Spivock was being moved then, and what they do is they plunk her—her clothes, as a matter of fact—things are missing after she's moved.

I had brought her some new clothes the time before they moved her and she never got to wear one of the dresses. It was just gone. They just plunk her down like she's a piece of baggage and put her wherever they want her without any rights.

I was going to buck that the best I could. I was getting nowhere. But the ombudsman got what we wanted, and the psychiatrist was called in. Of course, mama was found fine. It was just that she was being drugged actually to keep her quiet. And I'm wondering how many people are being treated that way today.

Ms. **Snowe**. I'm pleased that it all worked out, finally.

Ms. **Rosenfield**. We changed doctors, by the way.

Ms. **Snowe**. Again, I thank you both.

Mr. **Wyden**. Well, thank you both for an excellent job. I thought that last point that you made, Ms. Tulloch, about how very often the process starts adversarial, someone new comes in and then the process gets on the right track. It's almost as if there is fear of the unknown, and because of your very good advocacy for older people, and your writing, there won't be so many of those situations because we'll know more about this program, we'll know more about what it can accomplish. And I just want you both to know that I'm very appreciative of your coming, and helping to educate the subcommittee about what can be done under this program so we can really utilize it as a tool for seniors and their families. Thanks for a great job.

On our next panel is Dr. Arthur Flemming, a former U.S. Commissioner on Aging. To go through Commissioner Flemming's vitae would take us a good portion of the morning. But suffice it to say we in Oregon remember him from his very distinguished tenure at the University of Oregon in Eugene. For our purposes today, however, it's particularly important that he is here as the father of the Ombudsman Program. We're delighted to have him, and also Shirley Ellis, director of ombudsman services, Wisconsin Board on Aging and Long-Term Care.

We welcome both of you. We will make a copy of your prepared remarks a part of our hearing record today, and if you could summarize in 5 minutes or so your principal concerns, then we can move right on to some questions. Dr. Flemming, let's go ahead with you this morning.

STATEMENT OF ARTHUR FLEMMING, FORMER U.S. COMMISSIONER ON AGING, AND FATHER OF THE OMBUDSMAN PROGRAM

Mr. **Flemming.** Mr. Chairman, thank you very much. First of all, may I express to you and your colleagues on this committee my deep appreciation for your decision to take a look at this particular program and see just where it stands at the present time. And I certainly appreciate the opportunity of appearing before you in connection with your oversight hearing.

I'm not in a position to make an overall evaluation of the program as it stands today. I think that's perfectly obvious because I pick up information about it from time to time as I move over the country, but I've not been in a position to make an indepth evaluation of where it stands.

As one who served as Chairman of the U.S. Commission on Civil Rights for a period of 8 years, I participated in quite a number of oversight studies and hearings, and I learned that it was very important to assemble evidence and evaluate it before one arrives at findings and conclusions. But I will be very happy to share with the members of the committee some of my hopes and dreams for the program, and my own convictions relative to the role of the Federal Government in this area.

Then when you have compiled evidence relative to what is happening based on your field studies, and these hearings, I will be very happy to react to that evidence by providing you with my own recommendations relative to the future.

When I was serving as U.S. Commissioner on Aging I was impressed with the fact that there were many residents in nursing homes with valid complaints who did not have access to anyone who could serve as an advocate. I felt that we could set in motion a program under which it would be possible to channel complaints to a central point in the community, that a task force of volunteers drawn from panels of experts could be assembled, and it would be possible for the task force to stay with the complaint until it was resolved in a constructive manner.

I also believe that it should be possible to establish in the office of the head of the State agency on aging a position of ombudsman with the understanding that the incumbent would provide leadership for instituting this program throughout a State by working with the heads of the area agencies on aging.

I recognize that if the idea was to be implemented at the community level in an effective manner it would be necessary to provide the volunteers who would be at the heart of the program with adequate staff support.

As a result of arriving at these conclusions I authorized the establishment of the position of ombudsman in the offices of the head of the State agency on aging. I appreciated very much the contributions that my associate at the Administration on Aging, and the heads of State and areas agents on aging made in implementing the idea. Without their hard work it would have just been a dream.

I was delighted when after I left the position of U.S. Commissioner on Aging the Congress decided to incorporate the idea in an amendment to the Older Americans Act, an amendment which authorized and directed State agencies on aging to operate a long-term care Ombudsman Program.

And I've also been very happy to note that a number of States, listening to the testimony this morning, apparently it's up to about 21, have enacted similar legislation.

From the very beginning I have felt that if this program was to be successful on a nationwide basis that there should be a strong Federal presence in connection with the development and implementation of the idea. There's been no doubt in my mind at all, but that the Federal Government has an obligation and a responsibility to be concerned about quality of care in nursing homes, and in boarding care homes, in every community in every State in the Nation. With very few exceptions these institutions receive, and rightly so, Federal funds for care of residents. This means that the Federal Government must take the lead in developing programs that are designed to insure that the funds are expended in a manner that is consistent with the human rights and the concept of compassion that have been built into our way of life as a nation.

The Federal Government must recognize that the effective implementation of these programs depends on State and local government, that it must never turn its back on its overall responsibility and obligation. Therefore, I have found that the Administration on Aging should at all times provide strong national leadership for the Ombudsman Program by providing standards, assistance, and training, both support staff and volunteers, technical assistance on a regular schedule, a clearinghouse service that would enable the various programs to benefit from each others experiences, and financial assistance for the strengthening of the support staff.

I've also felt that the Administration on Aging should use the evidence developed by ombudsman for the purpose of advocacy in pressing both the executive and legislative branches for more effective regulatory programs under both Medicare and Medicaid.

I'm confident that one of the results of this committee's hearings and studies will be to point up both the strengths and weaknesses of the Federal Government's involvement in this work. When this has been done I will be happy, if the committee feels I can be of help, to provide you with my reaction.

I believe in the ombudsman concept. I feel that it is contributive to the improvement of the quality of care in a significant number of nursing homes, and boarding care homes. There are still many nursing homes operating in our Nation that do not measure up to acceptable standards as far as quality of care is concerned. And, of course, the same is true for boarding care homes.

I believe that a more intensive development of the Ombudsman Program on a nationwide basis would make a significant contribution to improving the Nation's record in the nursing home field, and in the boarding care area.

I believe that this intensive development will take place on a nationwide basis only if the Federal Government takes the lead.

I hope that the experiences we have had with the ombudsman concept in the field of aging will be analyzed to determine whether it could be applied to other areas, including, for example, the disability and handicap areas, and I certainly agree, Mr. Chairman, with you, that it is applicable. I would argue that it's applicable under present law to the home health care area.

Mr. WYDEN. Well, Dr. Flemming, thank you for a really excellent presentation. I know both my colleague and I will have some questions momentarily.

Ms. Ellis, we welcome you. We'll make a copy of your prepared remarks a part of the record, and if you could summarize in 5 minutes or so, we'll have some time for some questions. Welcome.

STATEMENT OF SHIRLEY A. ELLIS, DIRECTOR OF OMBUDSMAN SERVICES, WISCONSIN BOARD ON AGING AND LONG-TERM CARE

Ms. ELLIS. Thank you.

My name is Shirley Ellis. My appreciation to the members of the House Subcommittee on Human Services for allowing me to share my views on the status of the Long-Term-Care Ombudsman Program. I have submitted a written statement, and would like to summarize it.

I am the long-term-care ombudsman of Wisconsin employed by the board on aging. The agency is independent and located outside the State unit on aging. The ombudsman's organizational location should provide the following components in order for the program to be effective: Ombudsmen should be free from restraint, particularly from the conflicts of interest of a State licensing, regulatory, or reimbursement entity, of which the state aging unit may be a part of. Ombudsman programs are one of the few groups which exclusively focus on the needs of institutionalized persons. The State's unit's emphasis is on those persons over age 60 who are residing and functioning in the community. The institutionalized have been virtually ignored beyond ombudsman activities because they are viewed as having failed by not residing and functioning in the community. Further, ombudsmen should protect the rights of all institutionalized persons, not just those over age 60. This causes conflicts within a State aging unit. In Wisconsin 13 percent of the nursing home residents are under age 60. The younger institutionalized persons needs may be ignored without the intervention of the ombudsman.

Ombudsmen require high visibility within the State. In a State aging unit the ombudsman may be obscure because of the number of other activities performed by that agency.

The Wisconsin Board on Aging has derived great benefits from the utilization of the model outlined which separates the ombudsman from the State aging unit while still enjoying the benefits of a good working relationship with the State aging unit and the area agencies on aging.

Due to the existence of these conflicts of interest and role, serious consideration should be given to the revision of the Older Americans Act language which would require the Ombudsman Program to be contracted out, specifically, from those State aging units which license, regulate, or reimburse long-term care facilities. The act should also exclude agencies or boards which regulate, license, or reimburse long-term-care facilities from operating the program.

I reference you to my testimony outlining my serious concerns regarding AOA's responsibility to provide technical assistance, carry out a national clearinghouse function, and provide training to long-term-care ombudsmen. I believe AOA must address these concerns.

In Wisconsin, ombudsmen with a signed release may access patients' records. Presumably, in most States, if ombudsmen are denied access to records, a referral can be made to the State regulatory agency. However, in Wisconsin the regulatory agency does not have access to all patients' records. Due to Wisconsin's confidentiality statute, which is clearly in conflict with current Federal statutory and regulatory language, neither the regulatory agency nor the ombudsman have access to the records. The administration must enforce all laws, rules, and regulations.

I have wondered if this violation had affected the Deficit Reduction Act would Wisconsin have already received a disallowance of funds.

Not only is the statute illegal, the Wisconsin statute may actually foster and protect the practice of Medicaid discrimination, since no records can be reviewed. All the complaints the ombudsman have received regarding Medicaid discrimination have been either anonymous or confidential. Without a signed release neither the Ombudsman Program, nor the regulatory agency, can review the record.

Another problem with the Wisconsin confidentiality statute is that it negates any assurance that private pay residents are assessed properly. Facility staff can determine the level of care for private pay residents. A resident could require skilled care, and the facility could assess the person at a lower care level. The facility will be understaffed, and the quality of care would be diminished.

A more likely scenario is that the facility is assessing a lower care level resident as requiring skilled care. The resident is charged more money, depletes his savings, but is not necessarily guaranteed better care.

Neither the ombudsman, nor the regulatory agency, can do anything about the situation described because they do not have access to the records.

In addition to this, there has been discussion of the expansion of ombudsman duties. I offer the following recommendations for discussion when any expansion of the Ombudsman Program is considered:

One. Any Older Americans Act revision which would expand the Ombudsman Program activities should include adequate funds to carry out the expansion.

Two. The Older Americans Act should be revised to increase the allocation to reflect the Ombudsman Program's expansion to date, and adequately meet the needs of all institutionalized persons.

Three. The Older Americans Act revisions should require the allocation to be given to the Ombudsman Program regardless of other State or local contribution which are received by the Ombudsman Program. The State aging unit has a responsibility to older people regardless of their residence.

Four. Finally, the Older Americans Act language should be revised in regards to the involvement of area agencies on aging. The area agencies on aging should be required to expend a portion of their funds, just as State aging units are.

I appreciate the opportunity to present my views, and commend the committee for exploring the status of the Long-Term-Care Ombudsman Program. Please contact me if I can be of assistance as you continue your work in this area.

[The prepared statement of Ms. Ellis follows:]

PREPARED STATEMENT OF SHIRLEY A. ELLIS, DIRECTOR OF OMBUDSMAN SERVICES, WISCONSIN STATE LONG-TERM-CARE OMBUDSMAN

I. INTRODUCTION

My name is Shriley A. Ellis. I am the Long Term Care Ombudsman of the State of Wisconsin. I am grateful to Representative Biaggi and members of the House Subcommittee on Human Services for the opportunity to share my views on the status of the Long Term Care Ombudsman Program. I am employed by the Wisconsin Board on Aging and Long Term Care and wish to provide a brief description of the agency. The Board on Aging and Long Term Care is an independent state agency located outside of the state unit on aging. The Board on Aging and Long Term Care is composed of a seven member, administrative citizens board appointed by the Governor, which appoints an executive director to carry out the day to day operations of the agency, including hiring of staff. The Board has broad responsibilities which can be divided into four (4) distinct functions:

1. Policy

(*a*) Report annually to the Governor and Legislature.

(*b*) Provide recommendations for more effective and efficient coordination of elderly programs.

(*c*) Monitor actions taken by the agencies of the state to carry out the Board's recommendations and monitor the development and implementation of Federal, State and local laws, regulations, rules, ordinances and policies that relate to long term care facilities.

(*d*) Initiate legislation as a means of correcting inadequacies found while investigating concerns.

2. Case investigation

(*a*) The Board through its Ombudsman function investigates complaints from any person concerning improper treatment of aged or disabled persons who receive long term care or concerning noncompliance or improper administration of federal or state laws, rules or regulations relating to long term care.

(*b*) Through the Ombudsmen the Board serves as an advocate or mediator to resolve any problems or dispute related to long term care.

3. Training

(*a*) The Board promotes public education, planning, and voluntary acts to resolve problems and improve conditions involving long term care.

(*b*) The Board encourage resident, client, and provider participation in the development of programs and procedures involving resident councils.

4. Information

The Board provides information to the public on a wide array of issues ranging from public benefits to nursing home care.

The Board on Aging and Long Term Care has but one agenda: the identification of the long term care needs of the aging and disabled of Wisconsin and to serve as an adovcate or mediator to resolve the concerns/problems of the aging and disabled of Wisconsin. (Attachment I, Wisconsin Statutes Relating to the Board on Aging and Long Term Care).

The status of the Long-Term Care Omudsman Program is very important to the lives of institutionalized persons and Ombudsmen need additional support to insure quality of care, protect resident's rights and curb abuses. The areas in which, I offer suggestions and ask your serious consideration in this written statement are as follows:

(1) The importance of the organizational location of the Long Term Care Ombudsman Program and the preference of an independent organizational location.

(2) The existence or degree of technical assistance provided to the Long Term Care Ombudsman Program by the Administration.

(3) Ombudsman's right to access the patient's records when investigating a complaint.

(4) Whether or not the Long Term Care Ombudsman Program should be expanded in the future.

II. ORGANIZATIONAL LOCATION

(1) Ombudsmen should be free from restraint, or any conflicts of interest. Ombudsmen do not license, regulate or reimburse any long term care facilities. The state unit on aging may license long term care facilities or be under the jurisdiciton of a state agency which licenses, regulates or reimburses long term care facilities.

(2) A high priority should be given the Ombudsman Program as well as a recognition of the importance of Ombudsman activities. The Ombudsman Program requires ready access to the director of the agency. Several bureaucratic layers can exist between an Ombudsman and the state aging unit director.

(3) The Ombudsman Program is the only Title III Program under the Older Americans Act which provides direct service within the state aging unit. Therefore, an Ombudsman may encounter the difficulties and misunderstandings of an administration which is juggling two distinctly differing roles, of contracting and monitoring services versus the provision of direct services.

(4) Ombudsman Programs are one of the few groups which exclusively focus on the needs of institutionalized persons. The state units' emphasis historically has been placed on those persons over age 60 who are residing and functioning in the community. Consequently, the institutionalized persons needs may be virtually ignored beyond Ombudsman activities because the institutionalized person is viewed as having failed by not residing and functioning in the community. Further, Ombudsmen should protect the rights of all institutionalized persons, not just those over age 60. This may cause conflicts within a state aging unit. The number of institutionalized persons under age 60 is small and would not unduly drain resources. In Wisconsin, there are 49,227 nursing home residents, 6,493 are under age 60. (The younger institionalized persons needs may be ignored without the intervention of the Ombudsman).

(5) Ombudsmen require high visibility within the state. In a state aging unit, the Ombudsman may obscure because of the number of other activities performed by the agency.

The Wisconsin Board on Aging and Long Term Care has derived great benefits and growth from the utilization of the model outlined, which separates the Long Term Care Ombudsman from the state aging unit, while still enjoying the benefits of a good working relationship with the state aging unit and area agencies on aging.

Due to the existence of these conflicts of interest and role, serious consideration should be given to the revision of the Older Americans Act language which would require that the Long Term Care Ombudsman Program be contracted out, specifically, from those state aging units which also license long term care facilities or any state agency unit under a department, which licenses, regulates, or reimburses long term care facilities. Further, the act should exclude agencies or boards responsible for licensing nursing home administrators, certificate of need agencies or any agency or board which has other regulatory responsibilities from administering the Long Term Care Ombudsman Program.

III. EXISTENCE OR DEGREE OF TECHNICAL ASSISTANCE PROVIDED TO THE OMBUDSMAN PROGRAM BY THE ADMINISTRATION

Ombudsmen need the following services from the Administration:

(1) Collection and dissemination of information regarding long term care issues. This includes statistical data and educational materials on substantive issues.

(2) Meetings of State Long Term Care Ombudsmen should be convened for training purposes.

(3) Evaluation of the Long Term Care Ombudsman Program should be conducted to determine compliance with the Older Americans Act provisions.

The Administration has provided the Ombudsman Program little, in its ten year existence, toward meeting these board needs.

Section 202 of the Older Americans Act provides the authority, for the Administration on Aging, to provide the services listed above. I respectfully submit the following recommendations, to incure the Administration on Aging begins to adequately meet the Long Care Ombudsman Program needs:

(1) The Administration on Aging should provide to the Long Term Care Ombudsman Program a summary of the Ombudsman annual reports, on an annual basis. This summary would include: statistical data; laws which were passed in each state affecting long-term care; a list of all State Ombudsmen as well as a brief description of their organizational location; local program information; funding sources; and a list of major long term care concerns as identified by each state. If the Administration on Aging finds it cannot perform this role, it should contract out this responsibility to another agency with knowledge of long term issues.

(2) The Administration on Aging should be required to convene Ombudsmen yearly for training purposes. The Administration on Aging should elicit input from individual Ombudsman as well as organizations which represent them such as the National Association of State Long Term Care Ombudsman Programs and the National Citizens Coalition for Nursing Home Reform as to the focus and scope of the training. Further, the Administration on Aging should convene regional meetings twice yearly for Ombudsmen training.

(3) The Administration on Aging should be required to perform a clearinghouse function to provide up-to-date, current information on substantive issues, such as Medicaid discrimination, DRGs, and nursing home reimbursement systems, and other issues which could be identified from the "Summary of Ombudsman Annual Reports". In the event this highly technical assistance cannot be provided by the Administration on Aging it should be contracted out to an agency with a demonstrable background and involvement in long term care issues.

(4) The Administration on Aging should be required to provide a centralized staff person or persons to respond to questions from Ombudsmen and provide information, coordination, and training to the Administration on Aging/Regional staff persons.

(5) The Administration on Aging should form an Ombudsmen task force which in addition to other duties, could aid in the development of an evaluation tool to accurately assess the compliance of the Long Term Care Ombudsman Program with the provisions in the Older Americans Act. Presently, these assessments tend to be proforma with little constructive change resulting from them. The National Association of State Long Term Care Ombudsman Programs and National Citizens Coalition for Nursing Home Reform should be consulted in the formation of this task force.

6. Finally, the Administration on Aging must enforce all of the provisions of the Older Americans Act.

IV. OMBUDSMAN'S RIGHT TO ACCESS THE PATIENT'S RECORDS WHEN INVESTIGATING A COMPLAINT

The Older Americans Act states "the state will give assurances which would establish procedures for appropriate access by the Ombudsman to long term care facilities and patient records." In Wisconsin, Ombudsmen with a signed release may review patients records. The release specifies:

(1) The type of information to be released.

(2) The agency, organization or individual who will receive the information.

(3) The purpose of the release of information and;

(4) The effective time frame and/or conditions for release. Either the resident or authorized person signs the release.

Allowing for the release of information in this manner is appropriate access because Ombudsmen are not regulators. Presumably in most states, if the Ombudsman is denied access to records, a referral can be made to the state regulatory agency which would have the authority to do so. However, in Wisconsin the regulatory agency does not have access to all patients' records due to Wisconsin's Confidentiality Statute, Section 146.82 (Attachment II, Wisconsin's Confidentiality Statute, Section 146.82). Under the confidentiality statute, Wisconsin's regulatory agency is permitted to examine records of all patients in nursing homes for the purposes of facility licensure or certification. However, a private pay resident may deny access by the regulatory agency or another state or federal agency to his/her records, by annually submitting to the nursing home a signed, written request on a form provided by the Wisconsin Department of Health and Social Services.

Wisconsin's statute is clearly in conflict with current Federal statutory and regulatory language dealing with Health Care Financing Administration's (HCFA) access to patient's medical records. This was confirmed in a letter to Wisconsin's regulatory agency from Sharon Harris, Acting Director, Office of Survey and Certification, HCFA, Department of Health and Human Services, dated March 14, 1985.

(Attachment III, Health Care Financing Administration and Attachment IV, Wisconsin's Regulatory Agency's Inquiry to Health Care Financing Administration).

The Administration although informed of the problems with this statute did not intervene. It instead referred the regulatory agency to another division within the Administration. The Administration must enforce laws, rules and regulations. I have wondered if this violation had affected the Deficit Reduction Act would Wisconsin have already received a disallowance of funds.

Not only is the statute illegal the Wisconsin statute may actually foster and protect the practice of Medicaid discrimination, since no records can be reviewed (in some facilities every private pay resident has signed the denial of access form). Residents and families may have waived their rights because of improper information. All of the complaints the Board on Aging and Long Term Care has received regarding Medicaid discrimination have been anonymous or confidential. Without a signed release neither the Board on Aging and Long Term Care nor the regulatory agency can review the records.

Another problem with the statute is that it negates any assurance that private pay residents are being assessed at the appropriate level of care in Wisconsin. This is important because facility staffing ratios are determined by the number of residents in the facility, as well as, the residents' level of care.

The facility staff can determine the level of care for private pay residents, with skilled care being the highest level. There are two issues here. Although unlikely, a resident could require skilled care and the facility could assess the person at a lower care level. The facility could therefore, be understaffed and the quality of care diminished. A more likely scenario, however, is that the facility is assessing a lower care level resident as requiring skilled care. The resident is charged more money, depletes his savings but is not necessarily guaranteed better care.

Neither the Ombudsman nor the regulatory agency can do anything about the above situation because they do not have access to the resident's records.

V. SHOULD THERE BE FUTURE EXPANSION OF THE OMBUDSMAN PROGRAM

The Ombudsman Program has been expanded officially to investigate the concerns of the institutionalized in board and care facilities. The vast majority of Ombudsmen were investigating the concerns of board and care residents prior to this expansion. However, Ombudsmen also receive inquiries/complaints regarding other long term care concerns not involving institutionalized persons such as home health care. The time and energy spent answering and sometimes investigating these unofficial duties can be enormous. As stated earlier expansion of the Ombudsman Program has been occurring informally, for years. Ombudsmen have been resistant and reluctant to have formalized expansion and for good reasons:

(1) Ombudsman Programs are not presently being funded at levels adequate for conducting effective Ombudsman activities statewide.

(2) The increase of duties may reduce effective Ombudsman activities for institutionalized persons.

(3) An increase in duties does not necessarily provide more funding. No increase of funding was granted to Ombudsman Programs to investigate board and care facilities. In Wisconsin's last legislative session, the Board on Aging and Long Term Care was given the responsibility of monitoring the State's Community Options Program. The Community Options Program provides services (home health care, respite care, homemaking services) to persons who are in danger of being institutionalized without such intervention. The Board on Aging and Long Term Care was not given additional funds to carry out this new responsibility.

Ombudsman Programs can currently recieve 1% or $20,000, whichever, is greater from funds allotted under Section 304(a) of the Older Americans Act. The section further states, "the requirement of this clause shall not apply in any fiscal year in which a state spends from state or local resources an amount equal to the amount required to be spent by the clause". Although, the Wisconsin Board on Aging and Long Term Care receives more in other state allotted funds than the Older Americans Act requirement, the state aging unit does contribute 1% of the state's allocation. This is due primarily to the state aging unit's recognition of the importance of the Ombudsman's role. (Wisconsin's state aging unit director is a former Ombudsman).

While Ombudsman Programs are willing to accept complaints on any long term care issue on an informal basis, it is reluctant to do so formally without the necessary resources. Ombudsman Programs have continued to receive 1% of the states allocation of Older Americans Act funds even with an expansion in duties to serve residents of board and care facilities.

I offer the following recommendations for discussion when any expansion of the Ombudsman Program is considered:

(1) Any Older Americans Act revisions which would expand the Ombudsman Program activities should include adequate funds to carry out the expansion.

(2) The Older Americans Act should be revised to increase the allocation from 1% to 3% to reflect the Ombudsman Program's expansion to date and adequately meet the needs of institutionalized persons.

(3) Also, the Older Americans Act revisions should require the 3% allocation be given to the Ombudsman Program regardless of other state or local contributions which are received by the Ombudsman Program. The state aging unit has a responsibility to older people regardless of their residence.

(4) Finally, the Older Americans Act language should be revised in regards to the involvement of Area Agencies on Aging. The Older Americans Act currently states, "the Area Agencies on Aging must undertake activities in support of the Ombudsman Program". The role of the Area Agencies on Aging needs to be precisely defined in regards to the Ombudsman Program. State Aging Units are required to spend a certain minimum amount for the operation of the Ombudsman Program. The Area Agencies on Aging should also be required to expend a portion of their Title III-B social services funds for the operation of the Ombudsman Program.

I appreciate the opportunity to present my views and commend the committee for exploring the status of the Long Term Care Ombudsman Program. Please contact me if I can be of assistance as you continue your work in this area.

[Attachment I]

WISCONSIN STATUTES RELATING TO THE BOARD ON AGING AND LONG-TERM CARE

15.07 Boards. (1) Selection of Members. (a) If a department or independent agency is under the direction and supervision of a board, the members of the board, other than the members serving on the board because of holding another office or position, shall be nominated by the governor, and with the advice and consent of the senate appointed, to serve for terms prescribed by law.

15.105 (10). Membership. Board on Aging and Long Term Care. There is created a board on aging and long term care, attached to the department of administration under s. 15.03. The board shall consist of 7 members appointed for staggered 5-year terms. Members shall have demonstrated a continuing interest in the problems of providing long term care for the aged or disabled. At least 4 members shall be public members with no interest in or affiliation with any nursing home.

16.009 Board on Aging and Long-Term Care. (1) The board on aging and long term care shall:

(a) Appoint an executive director outside the classified service to serve at the pleasure of the board. The executive director shall supervise day-to-day implementation of the board's functions and shall appoint staff outside the classified service to perform these functions.

(b) Investigate complaints from any person concerning improper conditions or treatment of aged or disabled persons who receive long term care or concerning noncompliance with or improper administration of federal or state laws, rules or regulations related to long term care for the aged or disabled.

(c) Serve as mediator or advocate to resolve any problem or dispute relating to long term care for the aged or disabled.

(d) Promote public education, planning and voluntary acts to resolve problems and improve conditions involving long term care for the aged or disabled.

(e) Monitor the development and implementation of federal, state and local laws, regulations, rules, ordinances and policies that relate to long term care facilities for the aged or disabled.

(f) As a result of information received while investigating complaints and resolving problems or disputes, publish material that assesses existing inadequacies in federal and state laws, regulations and rules concerning long term care for the aged or disabled. The board shall initiate legislation as a means of correcting these inadequacies.

(g) Stimulate resident, client and provider participation in the development of programs and procedures involving resident rights and facility responsibilities, by establishing resident councils and by other means.

(h) Conduct statewide hearings on issues of concern to aged or disabled persons who are receiving or who may receive long term care.

(1) (em) Monitor, evaluate and make recommendations concerning long term care services received by clients of the long term support community options program under s. 46.27.

(1) (j) Provide information to consumers regarding insurance policies available to supplement federal medicare insurance coverage.

(1) Report annually to the governor and the legislature. The report shall set forth the scope of the programs for providing long term care for the aged or disabled developed in the state, findings regarding the state's activities in the field of long term care for the aged and disabled, recommendations for a more effective and efficient total program and the actions taken by the agencies of the state to carry out the board's recommendations.

(2) The board on aging and long term care may contract with any State agency to carry out the board's activities.

50.02 (4) Reports to the Board on Aging and Long-Term Care. The department shall submit at least one report quarterly to the board on aging and long term care regarding enforcement actions, consultation, staff training programs, new procedures and policies, complaint investigation and consumer participation in enforcement under this subchapter. The department shall submit at least one report annually to the board on aging and long term care regarding implementation of rules under sub. (3) (d).

[Attachment II—Wisconsin's Confidentiality Statute]

146.80 MISCELLANEOUS HEALTH PROVISIONS

146.82 Confidentiality of patient health care records. (1) CONFIDENTIALITY. All patient health care records shall remain confidential. Patient health care records may be released only to the persons designated in this section or to other persons with the informed consent of the patient or of a person authorized by the patient.

(2) ACCESS WITHOUT INFORMED CONSENT. (a) Notwithstanding sub. (1), patient health care records shall be released upon request without informed consent in the following circumstances:

1. To health care facility staff committees, or accreditation or health care services review organizations for the purposes of conducting management audits, financial audits, program monitoring and evaluation, health care services reviews or accreditation.

2. To the extent that performance of their duties requires access to the records, to a health care provider or any person acting under the supervision of a health care provider or to a person licensed under s. 146.35 or 146.50, including but not limited to medical staff members, employes or persons serving in training programs or participating in volunteer programs and affiliated with the health care provider, if:

a. The person is rendering assistance to the patient:

b. The person is being consulted regarding the health of the patient; or

c. The life or health of the patient appears to be in danger and the information contained in the patient health care records may aid the person in rendering assistance.

3. To the extent that the records are needed for billing, collection or payment of claims.

4. Under a lawful order of a court of record.

5. In response to a written request by any federal or state government agency to perform a legally authorized function, including but not limited to management audits, financial audits, program monitoring and evaluation facility licensure or certification or individual licensure or certification. The private pay patient may deny access granted under this subdivision by annually submitting to the health care provider a signed, written request on a form provided by the department. The provider, if a hospital or nursing home, shall submit a copy of the signed form to the patient's physician.

6. For purposes of research if the researcher is affiliated with the health care provider and provides written assurances to the custodian of the patient health care records that the information will be used only for the purposes for which it is provided to the researcher, the information will not be released to a person not connected with the study, and the final product of the research will not reveal information that may serve to identify the patient whose records are being released under this paragraph without the informed consent of the patient. The private pay patient may deny access granted under this subdivision by annually submitting to the health care provider a signed, written request on a form provided by the department.

7. To a county agency designated under s. 46.90(2) or other investigating agency under s. 46.90 for purposes of s. 46.90 (4)(a) and (5). The health care provider may release information by initiating contact with the county agency without receiving a request for release of the information from the county agency.

(b) Unless authorized by a court of record, the recipient of any information under par. (a) shall keep the information confidential and may not disclose identifying information about the patient whose patient health care records are released.

History: 1979 c. 221; 1983 a. 398.

[Attachment III—Letter from Health Care Financing Administration]

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
HEALTH CARE FINANCING ADMINISTRATION,
Baltimore, MD, March 14, 1985.

Mr. LOUIS E. REMILY,
Deputy Director, Bureau of Quality Compliance, Wisconsin Department of Health and Social Services, Madison, WI.

DEAR MR. REMILY: This is in response to your recent letter reegarding the authority of State survey agencies to review the medical records of private pay patients in skilled nursing facilities (SNFs).

Federal regulations implementing Section 1866 of the Social Security Act, "Agreements with Providers of Services," provide substantial support for the Health Care Financing Administration's (HCFA's) authority to review *all* patients and their records in determining compliance by providers with the conditions of participation for skilled nursing facilities. For example, the Patients' Rights standard of the SNF regulations, 42 CFR 405.1121(k), clearly states that patients' rights policies apply to "each patient admitted to the facility." Further, under the Medical Records condition, 42 CFR 405.1132, facilities are required to "maintain clinical (medical) records on all patients in accordance with accepted professional standards and practices." With the exception of utilization review requirements, the entire conditions of participation are cast in terms of all patients, rather than being restricted solely to Federal beneficiaries. Termination procedures (42 CFR 489.53) then assert that HCFA may terminate a provider agreement if a facility fails to meet the appropriate conditions of participation or if a facility fails to treat Federal beneficiaries the same as all other persons seeking care.

A number of other legitimate rationales can be advanced in support of the authority of HCFA, and on its behalf, the State agencies, to review the care and medical records of private pay patients. Agreements between providers and HCFA certify that the facility has demonstrated its ability to provide Medicare-approved services. It is the provider which is being approved, not just the beds of Federal beneficiaries. Thus, we often enter into agreements with providers having very few or no resident beneficiaries, based on survey samples consisting entirely of private pay patients. Without such surveys, providers could not quality for Medicare participation and establish eligibility for reimbursement until a significant care record for Federal beneficiaries was established. Such a system would be inherently unfair to both providers and beneficiaries.

The area of reimbursement is another which exemplifies HCFA's need for access to both private pay and beneficiary records. Provider payment rates are established based on reasonable costs and customary charges for care and services. Determination of such costs necessitates the review of private pay records to assure that costs incurred by beneficiaries are reasonable and customary. Referring to payment information, Section 1866(b)(2)(C) of the Social Security Act empowers HCFA to terminate a provider agreement if the provider refuses to permit "examination of its fiscal and other records by or on behalf of the Secretary as may be necessary to verify such information."

Both the traditional nursing home survey process and the experimental Patient Care and Services (PaCS) survey system depend on surveyor access to records of all patients in a facility. Surveyors under both systems review a sample of patient records, rather than each patient record, but the sample is drawn from the total facility population without differentiation as to source of payment for care. The PaCS system then does not institute any change for survey agencies in terms of the available medical record base, and the same confidentiality and disclosure protections continue to apply.

The Wisconsin statute referenced in your letter is clearly in conflict with current Federal statutory and regulatory language dealing with HCFA's access to patient medical records. If you anticipate any potential conflicts concerning this issue, you may wish to contact the Department of Health and Human Services' Regional Attorney, Donna Weinstein, at (312) 353-1640. We are forwarding copies of your letter and this reply to her office.

Sincerely yours,

SHARON HARRIS,
Acting Director,
Office of Survey and Certification.

[Attachment IV—Letter of Inquiry to Health Care Financing Administration from Wisconsin's Regulatory Agency]

STATE OF WISCONSIN,
DEPARTMENT OF HEALTH AND SOCIAL SERVICES,
Madison, WI, February 26, 1985.

TRISH SHARP,
Office of Survey and Certification, Division of Data Program Analysis, Baltimore, MD.

DEAR MS. SHARP: Attached is a copy of Section 146.82(2)5, Wis. Stats., relating to confidentiality of patient health records and a copy of a Commerce Clearing House summary of a U.S. District Court for New Hampshire ruling that survey agencies may review *all* records in SNF facilities certified for Medicare or Medicaid programs.

In addition to this Court decision, the Wisconsin Legislative Council, Special Committee on Regulation of Nursing Homes, Rodney C. Moen, Senator and Committee Chairperson, is interested in obtaining written confirmation that under the Patient Care and Services (PaCS) survey system, now being piloted in Wisconsin and other states, that survey agencies are to review all residents' records, regardless of source of payment for care, in the resident sampling part of the survey.

An early response would be appreciated since the next meeting of the Committee on Regulation of Nursing Homes will be held on March 13, 1985. Senator Moen has indicated that this issue will be considered at that time.

Sincerely,

LOUIS E. REMILY,
Deputy Director,
Bureau of Quality Compliance.

Mr. WYDEN. Thank you both for excellent presentations. Dr. Flemming, of course, in Oregon in the aging field, you were a household word when I was codirector of the Oregon Gray Panthers. We are still trying to follow-up on some of your good ideas. You might be aware that I've sponsored legislation to make it easier for the private insurance companies to move into the long-term care field. I think we're going to be able to make that part of the Medicare package this year, and I know those are concepts that you've talked about for some time. We're just very honored to have you. Truly you are the father of this program, and your comments and insight are helpful for that reason and because of just your vast experience in the field.

The first question that I have is do you think that the Reagan administration through the Administration on Aging has made a strong enough commitment to this program? For example, I think you were here when we talked with Mr. Suzuki. We haven't gotten reports from the States now for years, and Mr. Suzuki said it was because of some confusion in the reporting requirements. It seemed to me if the Administration on Aging had a truly strong commitment to something like this they could probably in a matter of a couple of months straighten out some confusion in the reporting requirements, and make sure that we could get this kind of information in a prompt and constructive fashion.

My first question to you is do you think the administration really is committed to this program?

Mr. FLEMMING. I did listen to the testimony, and I agree with your conclusion, as far as the response to your question is concerned, because it seems to me that if the Administration on Aging is going to exercise reflective leadership, it's imperative for the Administration on Aging to be up-to-date on what is going on in the various States, and in the various communities. And I appreciate that computers do raise—do create problems from time to time in connection with reporting systems, but nevertheless, I believe that it is possible to institute reporting systems that will provide an administrator with timely information as to what is going on in a particular area.

And as Commissioner on Aging, I always felt that if I was to function effectively in connection with this program, or any other program, it was essential for me to have before me up-to-date information as to what was actually happening out in the field.

And that may very well be asymptomatic of the approach on the part of the administration to this particular problem. I'm sure you're going to get additional evidence which will bear on that particular question.

As I indicated in my opening testimony, once you've assembled that evidence, I'd be very glad to take a look at it, and I'd be very glad to give the benefit of my conclusions and recommendations because I don't think, looking at it from the standpoint of the Nation as a whole, that the country is going to benefit to the extent that it should from a program of this kind unless, as I indicated on my testimony, there is a strong Federal presence.

And I feel that out of the grassroots there is support for a strong Federal presence in relation to a program of this kind, and I feel assured that the Congress would be responsive to recommendations from the executive branch designed to strengthen that presence.

Mr. WYDEN. Just one other question for you, Dr. Flemming.

From the standpoint of training—you have been at this now for 10 years as an advocate for this program—do you feel that we have done as much in the training field as you feel we should have in the last decade?

Dr. FLEMMING. Again, listening to the testimony, and on the basis of some information, it's scattered information, but I've picked up, I believe that the Federal Government could have made, and should make, a more significant investment in that particular area. It will pay dividends.

For example, the issue that my colleague has raised here on—of access to records, now, that's an issue that everyone confronts throughout the Nation. How do you approach that? How do you get at it in the light of State laws, and so on? And I can see established a very significant training session on that.

It so happens that I've been serving on the board and chair for a number of years, legal counsel for the elderly here in the District of Columbia, and the Office on Aging here in the District of Columbia contracted with the legal counsel for the elderly for the ombudsman process. And I'm serving on the committee that's working with the people that are implementing that particular contract.

The first question that comes up is the question of access to records, and it's a confused picture right here in the District of Columbia. And immediately people begin reaching out for information as to how other States are handling it, and so on. And as far as I could determine on the basis of the initial discussion, that information is readily available anyhow.

But, no, if the Federal Government would invest in that training it would pay dividends in terms of the service that the ombudsman would be able to render older persons throughout our Nation.

Mr. **Wyden**. Dr. Flemming, thank you. Ms. Ellis, I'm not going to ask any questions of you right now, but your presentation I thought was just first rate. Particularly on this question of records, it is almost like peeling an onion. I mean, you get started in that area, and you find more and more to do. I've been involved in the records issue in a number of areas both in terms of privacy and the need, in some instances, for society to have disclosure. We're now facing the problem of tampering with computerized records and problems of criminal wrongdoing. We try to wade through these problems and really come up with a policy with respect to access to records.

Those of you who are on the front lines who are trying to run services for older people, you're going to have to give us a lot of counsel. I really appreciate your bringing the issue to our attention because the more we look at it frankly, the more problems we uncover. A comprehensive policy is going to be very necessary.

Let me recognize my colleague from Maine.

Ms. **Snowe**. Thank you, Mr. Chairman. I would like to thank both of you for appearing here today, and for your outstanding presentations. Dr. Flemming, it certainly is a privilege to have you here to share with us your perspective given your vast experience in this area. I certainly appreciate the fact that you are willing to take the time to give us your thoughts on this program.

Since you are the father of this program, how does the program today compare to they way in which you envisioned it when you first developed the Ombudsman Program?

Dr. **Flemming**. I am very pleased with the way it's developed, and actually it includes things now that I didn't envision at that particular time.

As I indicated to you in my opening testimony I simply saw out there a situation that I felt could be handled by, in effect, tapping the resource that is represented by volunteers, or willing to commit time to working on specific cases, but I also recognize that you just wouldn't get that kind of a contribution unless there was staff support, unless some person in the community was put in a position where she or he could marshal those resources.

And I felt that under our system of Government that the thing to do was to provide the State Offices on Aging with the opportunity of providing leadership that would, in turn, produce that kind of a result at the community level.

So that as I've watched it evolve, and as I listened to testimony from people who have worked with the program, I have been very pleased. As I travel over the country I do have the opportunity of talking with ombudsmen, but in the State of Maine I recognize that the present director of the State agency on aging came into the field really through the Ombudsman Program.

Ms. **Snowe**. Trish Riley.

Dr. **Flemming**. That's right. And she certainly is an outstanding leader in the field of aging; did an outstanding job as an ombudsman, and is doing an outstanding job as the head of the Office on Aging.

And as I have the privilege of becoming acquainted with those who are working in the field, I'm very, very much impressed with their commitment to the objective. So that I would have to say that I'm pleased with what is happening, even though I recognize that the—there are tremendous opportunities out there that are not being realized, and that could be realized if some of the things they've been talking about earlier could happen.

I agree that undoubtedly additional resources can and should be invested in the program, resources that sometimes would be represented by additional training opportunities, sometimes by additional technical assistance, and so on. All of those things can and need to be done. But I think we're off to a good start.

But I go back to my principal point, if we're going—if all parts of the country are going to benefit from this concept, then we are very, very dependent on vigorous Federal leadership because the fact we get great satisfaction out of the fact that a program in X State is going very, very well, but it seems to me that as a nation, although we get satisfaction out of that, we can't be satisfied with the situation if in Y State there's a very ineffective program.

And if there is in Y State a very ineffective program, the Federal Government shares the responsibility for the fact. But it's an ineffective program. And the Federal Government shares the responsibility for the fact that older persons out there, institutionalized older persons out there, are not getting the help and assistance that could come from an Ombudsman Program.

After all, I still feel that this is a United States of America, and that the Federal Government must be concerned about what is happening or isn't happening in an area like this in any part of our nation.

Ms. SNOWE. I thank you for your comments, Dr. Flemming. It is my impression that the program is inconsistently enforced, or that it's not enforced at all. Whatever happens, happens. We have some regulations; but there's a lot of discretion left to the States which is all well and good, up to the point that the program is not carried out effectively, and that's, of course, when the Federal Government should step in. We should provide some funds.

Dr. FLEMMING. It seems to me the Federal Government does have a monitoring responsibility. I mean, after all, this is a Federal law now. This has been made a part of the Older Americans Act. And the Federal Government has a responsibility for seeing to it that it works. I mean, it doesn't do any good to put it into a law if somebody doesn't accept the responsibility for seeing to it that it is implemented. And implemented throughout the Nation.

And as this committee explores, what the Federal Government is doing, or isn't doing, I hope that it will explore from that point of view; namely, that the law itself recognizes the acceptance of a responsibility on the part of the Federal Government. The Congress has recognized that responsibility and obligation.

Now, has the executive branch recognized that responsibility and obligation to the extent that it should? And under our system of Government unless the executive branch does, why, the—what the legislative branch does doesn't carry the same—doesn't carry the meaning that it should carry.

Ms. SNOWE. Thank you, Dr. Flemming.

Ms. Ellis, I noticed throughout your testimony that you've provided numerous suggestions as to how the program could improve, particularly at the Federal level.

I gather that one of the problems is enforcement on the part of the administration. First of all, how long have you been in this position?

Ms. ELLIS. Six years.

Ms. SNOWE. Six years. So your experience has been primarily with the Reagan administration. Perhaps 1 year under the Carter administration.

Well, have you noticed any difference at the Federal level in terms of implementing your responsibilities?

Ms. ELLIS. Well, your implementation at the Federal level was never as strong as it should have been.

Mr. Suzuki mentioned having regional meetings. I've been with the program for 6 years and Region V is having its first regional Ombudsman meeting when he plans to come to Chicago.

I don't believe regional meetings are indicative of the type of clearinghouse function ombudsman require or need from the administration. I believe ombudsman require regional meetings as well as a clearinghouse function: holding regional meetings was the response from the administration regarding a clearinghouse question posed to them from the subcommittee.

At one time a contract was given out by the administration to provide a clearinghouse function, and that did help. But presently, over the last 3 or 4 years, we have not had that kind of formalized information sharing, which is definitely needed. Ombudsman cannot constantly reinvent the wheel with the limited resources, especially monetary resources, available to them.

Ms. SNOWE. So the technical assistance the Administration on Aging renders is not on a regular basis, if at all?

Ms. ELLIS. I think it's been since the legislative overview that we've begun to have any type of movement from the AOA. Ombudsman in region V have requested regional training, meetings for the last 3 years. I believe a November 1985 regional training meeting will be the first for region V ombudsman. No; there has not been consistent or ongoing technical assistance or training from the Administration on Aging.

Ms. SNOWE. What kind of training did you receive in your position?

Ms. ELLIS. Actually Wisconsin's Ombudsman Program was one of the original pilot projects, so I was very fortunate when I came into the program. There was someone that could assist me. Other ombudsmen in our region and other regions were not so fortunate. They call us, other State ombudsmen and ask, "How can you help me?" I believe during the 6 years that I've been in this job I've helped to train at least five other State ombudsmen around the country. I do not believe my experience with other State ombudsmen is a unique one.

Ms. SNOWE. Thank you very much.

Dr. FLEMMING. Mr. Chairman.

Mr. **Wyden**. I thank my colleague. Dr. Flemming.

Dr. **Flemming**. Along the line of discussion we've been having I did have the opportunity of looking at a report or an executive summary of a report for the fiscal year 1981. Now, I don't know whether that's the last one, or whether there is one since then. I gathered from the testimony——

Mr. **Wyden**. Well, fiscal year 1982, I think, was the last one, which means if they get it to us in December it will have been almost 3 years.

Dr. **Flemming**. OK. Well, let me just say this. I'm sure the fiscal 1981 is available to the committee. And in the—I believe it's the introduction of that, there is a section on the impact of Federal requirements and support. And as I read that I had the feeling that in fiscal 1981, which is kind of a bridge fiscal year really, the Administration on Aging was headed in the right direction.

I could think of quite a number of other things that I would have added, but they talked about in the report—they talked about the fact that Older Americans Act regulations issued in March 1980 required area agencies on aging to carry out activities in support of the Ombudsman Program. The regulations also specified that the State agency must establish and operate a statewide Ombudsman Program. I mean, there was some reflection of Federal leadership here. Some people might argue about what was in the regulation, but nevertheless, there was an effort to exercise Federal leadership.

These were followed with Ombudsman Program guidelines issued by the Administration on Aging in January 1981. I don't know whether there have been any since then, or not, which Stated that full State coverage should be achieved by October 1982. That was setting up a standard of performance for people to achieve, and suggested the establishment of substate programs as an effective means of achieving statewide coverage.

During this same period the Administration on Aging provided resources, training, and technical assistance for Ombudsman Program development through supplemental grants to the State to support ombudsman and legal service activity, contract for biregional resource and support centers, and funding for the National Citizens Coalition for Nursing Home Reform, which provided valuable support to State and local ombudsmen.

Now, you're going to receive testimony later on from the executive director of the National Citizens Coalition for Nursing Home Reform. All I want to say is when they invested in that organization back in 1981 that was a good investment. I know that from experience on it.

But my point is that there seems to be movement as far as the Federal Government is concerned. I think it might be interesting to check and find out, you know, whether—to what extent that movement continued; to what extent the Administration on Aging built on the steps that are outlined in that fiscal 1981 report.

I'd also like to say this. That I personally appreciate, Mr. Chairman, very, very much the leadership that you've provided in the field of aging both in Oregon and here in the Congress, as I do the leadership of your colleague. And, of course, as you've indicated, I have a relationship with the State of Oregon, which I value very,

very highly, always welcome the opportunity of going back. And more recently a member of my family has joined the faculty of Bates College, so I'm related to your colleague's congressional district. And I've been hearing things from that congressional district.

So I'm just delighted to have the opportunity of being with both of you, and I do appreciate—to me, the oversight function on the part of congressional committees is so important, and I know how difficult it is to work it in with all of the other things.

But that function can mean everything in terms of really accomplishing the objective of somehow or other getting the executive branch to implement the will and the intent of the Congress. And that's why I'm delighted to participate in the process with you, and will be very happy to continue the participation if the committee so desires.

Mr. **Wyden**. Well, Dr. Flemming, let me state right now that we very much desire your continued participation. Your presentation was superb in every respect, and we're very appreciative. Ms. Ellis, as well, having been on the front lines for 6 years, you can really help us to see those aspects of the program that are most critical to good oversight. We thank you as well. I know we're going to call on both of you in the days ahead.

It's my own view, just personal, having sat here for an hour and a half and chaired this hearing, that there has been a significant dropping off in the commitment between 1981 and 1985. I think we need to figure out why and what we're going to do to turn the situation around. Your counsel and your contributions are going to make it easier to do it. We thank you.

Dr. **Flemming**. Thank you.

Mr. **Wyden**. Our next panel, Jim Varpness, president of the National Association of State Long-Term-Care Ombudsman Program, and Minnesota State Ombudsman; Julie Trocchio, director of the delivery of services, American Health Care Association; Elma Holder, executive director of the National Citizens Coalition for Nursing Home Reform; and Wilda Ferguson, commissioner, Virginia Department on Aging, and first vice president of the National Association of the State Units on Aging.

I want to welcome all of you. Let me say right at the outset that on this panel I'm going to have to vigorously enforce the 5-minute limitation only because I fear we will begin to hear all the buzzers and gongs and things like that.

So I will make a copy of your prepared remarks a part of the record. I know most of you have been here for a good portion of the morning, and if you could just highlight some of your principal concerns very briefly, then we can have some time for questions.

Why don't we begin with you, Mr. Varpness.

STATEMENT OF JIM VARPNESS, PRESIDENT, NATIONAL ASSOCIATION OF STATE LONG-TERM-CARE OMBUDSMAN PROGRAMS; AND MINNESOTA STATE OMBUDSMAN

Mr. **Varpness**. Thank you, Mr. Chairman. Thank you for the invitation for our association to appear today before you to discuss the Ombudsman Program needs and concerns. I have some brief oral remarks, and I'll provide some additional written testimony.

First, the effectiveness of the Ombudsman Program, in part, is attributed to the knowledge and information possessed by individual ombudsman themselves. The Older Americans Act recognizes this by requiring the State ombudsman to provide training to our local ombudsman and volunteers. Because training is a critical factor in assuring quality of ombudsman services, many of us have consistently requested training assistance through the Administration on Aging but with limited success.

Another key to providing nursing and boarding care home residents with capable and competent ombudsman services is assuring *that ombudsman keep informed* about emerging long-term care issues and trends impacting on residents, and negative facility behavioral patterns, and the State's actions in response to those patterns, including new laws and regulations. In addition, summary information on each State ombudsman activities, resources developed, and special projects needs to be shared by all of us. Not only can we gain new insights and ideas through such information sharing, but by doing so we avoid duplicating each others work.

To meet these goals, the Administration on Aging should develop with our association's input a national training program which includes orientation for new ombudsman, and ongoing training systems to address emerging problems identified through various State programs. In addition to training, a national clearinghouse function must be established through which we can share information and identify helpful resources.

While the Older Americans Act requires ombudsman to serve the institutionalized recipients of long-term care, some States are expanding or considering expanding their programs to serve the noninstitutionalized. This certainly makes sense to a lot of us, especially as we look at the demographics, and the growing number of elderly, utilizing alternative services with little or no protection or advocacy assistance. However, we also have some concerns. First, current Older Americans Act minimum funding requirements of the 1 percent, or $20,000, whichever is greater, is certainly insufficient to support current program clientele who make up over 5 percent of the elderly population. Before we look at expanding Ombudsman Program duties, which we could support, a funding formula must be adopted to insure that each State's program, whether in a State unit on aging, or freestanding, can operate an adequate statewide program with sufficient supportive staff, and resources, to do what is required. In doing so we will address the current inadequate funding levels of our programs and not further exacerbate them by taking on new duties. And finally, we need to address the level of funding which will be necessary for us to serve an expanded target group.

Ombudsman have a responsibility under the Older Americans Act to monitor laws and regulations relating to long-term care facilities, residents' rights and benefits, changes within the regulatory framework, and other areas impacting on the lives of residents. Because of our experience we are excellent sources for identifying problems and pointing out positive and negative trends within the system. The Older Americans Act recognizes this advocacy duty, and therefore, many of us believe that Circular A-122 does not apply to Ombudsman Programs performing their responsibility under the law. It certainly should not, for Ombudsman Programs will function merely as casework programs without the key element of using case experience to identify issues and advocate for systemic changes.

Long-term care consumers alone simply lack the resources to constructively put forward the concerns and ideas, and effectively advance the public policy objectives.

Ombudsman wrote letters to the Administration on Aging requesting clarification of Circular A-122 and its application to Ombudsman Programs. Our inquiries were referred to OMB with no response in over a year. For some programs there has been a chilling effect, which has become an impediment to effective systemic advocacy and Ombudsman Program operation.

Thank you, and I'll answer any questions.

Mr. WYDEN. Thank you very much. Ms. Trocchio, we're happy to have you here today. We'll make your prepared remarks part of the record, and if you could just highlight some of your concerns, we'll have some time for questions.

STATEMENT OF JULIE TROCCHIO, DIRECTOR, DELIVERY OF SERVICES, AMERICAN HEALTH CARE ASSOCIATION

Ms. TROCCHIO. Yes, Mr. Chairman. Good morning. I am Julie Trocchio with the American Health Care Association, the Nation's largest nursing home association, representing nearly 9,000 nursing homes and long-term care facilities.

We are pleased that you've asked us to come here today to discuss the Long-Term-Care Ombudsman Program, as it marks its 10th anniversary. Our testimony will discuss the progress that has been made since the program's inception, the results of a survey we made 2 years ago, and our suggestions for improvement.

It is not often that we find ourselves appearing before a committee like this with the mission of extending our compliments and praise, but that is basically what we have come here to do. Ombudsmen fulfill a vital role in ending the isolation of the elderly. Many nursing home residents have no families or friends to draw upon for support and assistance. Our association supports and encourages the assistance that ombudsmen give to nursing home patients in the resolution of their problems.

However, the first avenue of complaint resolution, we believe, rests with the nursing home administrator and his or her staff. We strongly feel that it is the nursing home staff's responsibility to be in close touch with the needs of the residents to hear and to respond to their problems or complaints they may have.

Recently AHCA undertook a survey among our State affiliates on the State Ombudsman Programs. Several generalizations can be drawn from the survey results.

First, there appears to be a correlation between low turnover in the State Ombudsman Program, and provider satisfaction. This suggests that program stability contributes to a successful program.

Second, there is high provider satisfaction in States where ombudsmen had relevant backgrounds in health, aging, and social work.

Finally, there was more satisfaction in States which have gone beyond the Federal law by developing their own ombudsman legislation. This may be because State legislation clarified many open and some troublesome issues.

We believe that three major areas within the Ombudsman Program have improved over the past 10 years. First is the area of staff training. The 1984 amendments strengthen this component.

Second, the training of volunteers has been promoted through AOA instructions. We hope that volunteer and staff training will continue to be upgraded.

A third area which has been improved is the extension of the Ombudsman Program authority to cover all long-term care institutions, not just nursing homes. Those in boarding care facilities are equally deserving of time and attention. In fact, AHCA believes that identification of unlicensed board and care facilities is a proper function of the Ombudsman Program which could result in substantial improvement in the safety of many frail and disabled people.

We have several suggestions for program expansion and improvement. As you are aware, there is virtually no Federal or State oversight in the home health and community-based service area. This is, we feel, a potentially explosive situation which should be addressed now before it is too late.

We are seeing an increasing number of elderly patients being discharged early from hospitals as a result of DRG's. We suggest there is a need for an external entity such as the Ombudsman Program to be involved and available to advocate for patients discharged to their home, and needing noninstitutional services. Are the elderly people getting the services they need? Is the quality of the care sufficient?

We also recommend there be a State level advisory body to each Ombudsman Program, and include provider representation. This would promote communication between providers and the Ombudsman Program.

In addition, we recommend that the Congress instruct the Administration on Aging to complete its manual of instructions for the Ombudsman Program, and other documents that give guidance on major issues not addressed in the legislation or implementing regulations.

It is our sincere hope that the ombudsman and nursing homes can continue to work in mutual cooperation. The broad authority that the long-term care Ombudsman Program enjoys is an ideal basis for long-term care providers and ombudsmen to work together on issues affecting the elderly. This, we believe, is an objective worth pursuing.

[The prepared statement of Ms. Trocchio follows:]

PREPARED STATEMENT OF JULIE TROCCHIO, DIRECTOR, DELIVERY OF SERVICES, AMERICAN HEALTH CARE ASSOCIATION

Mr. Chairman and Member of the Subcommittee, I am Julie Trocchio of the American Health Care Association, the nation's largest nursing home association, representing nearly 9,000 long term care facilities of all types and sponsorship. Collectively our members provide care to over 850,000 nursing home residents in a variety of inpatient settings.

We are pleased that you have asked us to come here today to discuss the Long Term Care Ombudsman Program (LTCOP) as it marks its tenth anniversary this year. Our testimony will discuss the progress that has been made since the program's inception, the results of a survey we made two years ago, and our suggestions for improvement.

Frequently, as an association, we appear before a Congressional Committee and present testimony criticizing some government spending cut or new regulation which may have been issued. It is with much less frequency that we find ourselves appearing before a committee with a mission of extending our compliments and praise. That is basically what we have come here today to do.

Many may have greeted the 1975 passage of the legislation creating the Long Term Care Ombudsman Program under the Older Americans Act with suspicion and unhappiness. Indeed, the vagueness and uncertainties associated with the legislation and its implementation may have fueled these concerns. The legislative and regulatory changes made over the intervening ten years, however, have served to improve the program and place it on the track of serving a valuable function for the elderly in long term care facilities. Many of the improvements were recommended by AHCA in previous testimony and comments on regulations and it is indeed gratifying to have meaningful input to a program that can benefit so many elderly citizens.

Ombudsmen can fulfill a vital role in ending the isolation of the elderly. Many of these individuals have no families or friends to draw upon for support and assistance. More than three-quarters of the women over age 75 in nursing homes have no husbands to visit them or to assure that their needs are being met. For some, the ombudsman may be the only outside visitor or resource they have to call upon if they have a problem. The ombudsman can serve as a vital link in cases such as these between the resident and the community. Our association strongly supports this key role for the ombudsman program.

As an association, AHCA supports and encourages the assistance ombudsmen give to nursing home patients in the resolution of their problems. The first avenue of complaint resolution, however, rests with the nursing home administrator and his or her staff. We feel strongly that it is the nursing home staff's responsibility to be in close touch with the needs of the residents and to elicit any problems or complaints they may have. It is a waste of too many idividuals' time for a simple complaint such as cold meals or insufficient linens to pass through the hierarchy and have to be addressed by the ombudsman. Certainly it is always in the best interests of the nursing home staff to resolve every problem that it can.

The role of the ombudsman in complaint resolution should properly be one of addressing only the problems insoluble at the facility level and of a serious enough nature to warrant the ombudsman's time. Obviously, as much responsibility lies with the facility as with the ombudsman for this model to work. There are too few ombudsman and too many elderly within and outside the walls of a long term care facility who could benefit significantly from the ombudsman's intervention for their time to be spent with issues easily resolved.

Another important function that ombudsman can perform is dealing with problems that go beyond affecting just one patient. For example, if a state were to make changes in its level of care definition for skilled and intermediate care patients, there is the potential of many frail elderly being discharged or losing their eligibility. The problems that his can lead to may cause severe stress and deterioration in health. In cases such as this, the ombudsman can be much more effective than nursing homes in successfully resolving the problem because the problem goes beyond one nursing home and affects all of the certified facilities in the state.

AHCA believes that any discussion of the ideal functioning of the ombudsman program must be predicated upon a good working relationship between the ombudsman and the nursing home staff. Both parties should assume the responsibility for a mutually effective arrangement and for delineation of roles. Much more can be accomplished if each party understands where the other is coming from, rather than assuming a hostile and adversarial posture. A former California state ombudsman, writing in the September 1985 *AHCA Journal* admitted that it is sometimes difficult to have a good working relationship with the provider when your job is perceived as one of only finding fault with the nursing home.[1] The author stresses. . . "the importance of building and maintaining effective communications with nursing home administrators and other long term care providers" as the key to a successful relationship and to avoid the image of an outsider whose role is primarily of nitpicking or interfering in the facility's business.

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[1] "An Ombudsman's Reflections on Communicating with the Provider", William Benson, American Health Care Association Journal, September 1985.

Cooperation between a long term care provider and the ombudsman must be a two-way street. Just as providers must understand the statutory role of the ombudsman, so too, must the ombudsman appreciate that there are perhaps 100 other patients in the facility with equally important needs. The staff of the facility may feel that the ombudsman has no experience or understanding of the day to day operations of the nursing home. Again mutual cooperation and communication can avoid these areas of potential conflict.

SURVEY ON OMBUDSMAN PROGRAM

In 1982, AHCA undertook a survey on the state ombudsman programs, with 27 of our 47 state affiliates responding. Although the survey was not intended to be scientifically valid, the information compiled is both interesting and useful. The materials submitted were classified as follows:

(1) Characteristics of programs in states where the state afficiates rated the program positively;

(2) Characteristics of programs in states where the state afficiates rated the program negatively;

(3) Completeness, quality and approach of specific materials such as training materials, procedural manuals and annual reports.

In addition, representatives of four state affiliates that gave highly positive responses and four with high negative responses were interviewed. Results of the survey are appended to this statement.

While the data and situation relative to each state may well have changed over the intervening three years, several generalizations may be drawn from the survey:

(1) There appears to be a high correlation between high turnover in a state's ombudsman program and provider dissatisfaction.

(2) There was a high provider dissatisfaction in states where ombudsmen had no relevant background in health, aging or social work.

(3) There was high dissatisfaction in states operating only under federal law and regulations, apparently because of their lack of clarity and specificity. In those states which have gone beyond the federal law and their own ombudsman legislation, provider satisfaction appeared higher because the state legislation clarified many "open" and troublesome issues.

The most significant problems identified by the survey was the inadequacy of training for volunteers. Although we have done no follow-up survey since our original one in 1982, we would venture a guess that this is much less a problem today, the reason being of course, the passage of the 1984 amendments and the AoA technical assistance to state programs, resulting in development and delivery of training programs in many states.

The importance of training for volunteers and staff had been singled out early on by AHCA as an area needing attention. In addition to addressing this problem, the 1984 amendments called for the consideration of the views of providers, older individuals and area agencies on aging in the development and operation of each state ombudsman program. Both of these provisions, which AHCA vigorously supports, are merely extensions of the principles we mentioned earlier: the need for meaningful communications between the parties involved and an understanding of the job each has to perform. We are particularly pleased by the number of state programs we have heard about in which providers and ombudsmen have participated in each others' training programs.

A third area which has been improved and addressed in the 1981 amendments is the extension of the ombudsman program authority to cover all long term care institutional providers, not just nursing homes. The problems encountered by the elderly are not limited to the nursing home setting. Those in board and care facilities are equally deserving of time and attention. Within the broad category of board and care are many unlicensed facilities which have fewer personnel and visitors than other facilities which also care for their health and medical needs. As a consequence the residents are more disenfranchised than they are in nursing homes or licensed board and care facilities where they often have access to a social worker, activities director and, often to their own resident councils to resolve any problems they might have. In fact, AHCA believes that identification of unlicensed board and care facilities is a proper function of the ombudsman program which could result in substantial improvements in the safety of many frail and disabled individuals.

SUGGESTED PROGRAM IMPROVEMENTS

Much has been written in the press over the past few months of the impact that the new hospital payment methodology, DRGs, are having on the elderly. The General Accounting Office has been studying the issue as has a number of other groups.

A recent study by the Southwest Long Term Care Gerontology Center can be added to those which have found that patients are being discharged from hospitals "quicker and sicker". A major portion of the burden for these patients is being placed on home and community-based services that are ill-equipped to handle their care needs. There is virtually no quality assurance or federal or state oversight in the whole home health and community-based services area. This is, we feel, a potentially explosive situation which should be addressed now before it is too late.

Nursing homes have reported to us that they are being asked to admit patients who are more acutely ill than ever before. They are finding that they must hire hospital-trained nurses and conduct specialized training for their staffs to care for patients who, until last year, had been treated in hospitals. As the above mentioned study points out, these changes require some rethinking of the service delivery system and funding priorities in long term care.

We suggest that it also raises the need for an external entity such as the ombudsman program to be involved and available to advocate for the patients discharged to home and utilizing home and community-based services.

In proposing the extension of the ombudsman program to home and community-based services, we are not suggesting that the monies currently allocated to the program are sufficient to fund such an extension. Congress would have to see the merit in this issue and appropriate the necessary dollars. In view of the serious nature of this problem, we would fully support this program expansion.

Other statutory changes which we have advocated in the past include:

Development of a state-level advisory body that includes provider representation would permit broader input into development of programs and policies. Existing advisory groups dealing with aging issues (such as a State Commission on Aging) should be permitted to provide this function.

Protection of provider due process rights to be addressed in the complaint resolution process. At a minimum, providers should be able to file a statement as part of the official record and be informed of the final outcome.

A prohibition against unions, union related organizations or other organizations having a definite conflict of interest performing local ombudsman functions should be included.

Authority for questions on confidentiality and access to medical records should be delegated to state law.

Inclusion of a requirement that complaints from providers be received and acted upon.

Finally, the state ombudsman program should be based in the state aging unit which should be prohibited from contracting major functions to any organizations or state government units with potential conflict of interest.

In addition to these legislative initiatives, we recommend that the Congress instruct the Office of Human Development Services in the Administration on Aging to complete its manual of instructions for the ombudsman program. It is important that guidance be provided on major issues not addressed in the legislation or implementing regulations. While existing chapters of the manual have addressed many of our concerns, dissemination of a competed document is essential.

AHCA also recommends that AoA be encouraged to expeditiously complete and disseminate its self evaluation program for substate ombudsman programs. We believe that these programs will assist ombudsmen in improving the effectiveness of their services to the benefit of the infirm elderly whom they serve.

In conclusion, our observation and analysis of the program since its inception have enabled us to identify elements that are characteristic of successful state programs. They include precise delineation of program purpose, procedures and practices; a highly qualified state ombudsman; a reasonable approach to sensitive issues such as privacy of medical records and access to facilities; well-trained volunteers and opportunity for meaningful provider involvement in program development and implemention.

It is our sincere hope that ombudsmen and nursing homes can continue to work in mutual cooperation. The broad authority that the Long Term Care Ombudsman Program enjoys, is an ideal basis for long term care providers and ombudsmen to work together on issues affecting whole segments of the elderly population. This, we believe, is an objective worth pursuing.

Three items are appended to this statement for inclusion in the official record:

(1)"An Ombudsman's Reflections on Communicating with the Provider", by William Benson, September 1985. American Health Care Association Journal.

(2) AHCA Statement on Long Term Care Ombudsman Program—January 1984.

(3) Questionnaire on Long Term Care Ombudsman Program—Results of Survey sent to 47 AHCA State Affiliates, January 1983.

An Ombudsman's Reflections on Communicating with The Provider

By William Benson

Early in my tenure as a state long term care ombudsman, I met with the chief administrator of a small chain of nursing homes to discuss his concerns about and behavior toward the local ombudsman program that had his facilities within its jurisdiction. He had demanded that we remove the volunteer ombudsmen assigned to his facility and had attempted to restrict the ombudsmen's access to his facilities in general.

The memory of that meeting remains quite vivid. He was blunt in his resistance to the program and candid in stating that he "saw red" each time an ombudsman tried to reach him. It was this administrator's view that ombudsmen represented nothing but problems; all they ever brought to his attention were complaints and criticisms about his facility, his employees and indirectly, if not directly, about him.

Although we had the statutory right of access to his facility, it was clear that unless some meeting of minds or understanding could be reached the program's interaction with him and his facilities would be hostile and difficult at best, making the successful resolution of residents' problems a time-consuming and stressful task. This candid exchange was one of my early lessons in the importance of building and maintaining effective communications with nursing home administrators and other long term care providers.

Discussion about concepts or techniques contributing to effective communication requires understanding of the context in which a particular interaction takes place. The context often depends upon the relationship of the parties to each other, such as communication between spouses, parent and child, employee and employer, labor and management, patient and doctor, and, for our purposes, between parties where conflict exists or the potential for conflict is high. This often characterizes the relationship between a nursing home provider and an ombudsman.

William Benson, who is currently a professional staff member with the Democratic staff of the U.S. Senate Special Committee on Aging, formerly served for over five years as California's State Ombudsman, overseeing a network of 35 local ombudsman offices and over 700 volunteers. Mr. Benson previously worked with the National Paralegal Institute training lay advocates to assist the elderly. He has worked in the field of aging since early 1973.

Understanding Each Other's Role

Often the major impediment to effective communication between ombudsmen and providers is a lack of knowledge or understanding about each other's role. For example, the role of the ombudsman as a complaint investigator and resolver, and as an advocate for the long term care facility resident, has not always been clear and, as a result, is not always accepted or appreciated. When the Long Term Care Ombudsman Program (LTCOP) began on a national basis in 1975, after its demonstration phase, it lacked a federal and state statutory base. Federal guidelines and direction were minimal and programs varied, often considerably, from state to state and even from community to community within a state.

When I was first appointed state ombudsman in 1979, the substate or local programs within my jurisdiction ranged from very aggressive advocacy groups to friendly visitor programs with an obvious dislike for dealing with conflicts. As providers from different cities and states exchanged stories, the inconsistencies and even contradictions in roles created understandable confusion by all parties as to the role and functions of the LTCOP.

The LTCOP was formally incorporated into federal law as part of the 1978 amendments to the Older Americans Act, which required each state to establish and operate the ombudsman program in conformance with federal requirements. The new law provided a common national framework and statement of purposes and for the first time, a national definition and understanding of the ombudsman were possible. Yet, nearly seven years later, there continues to be misunderstanding about the LTCOP role and function.

The more knowledgeable the ombudsman is about the facility that is the subject of the complaint investigation, the more prepared he or she is going to be to handle the problem effectively. Ombudsmen must have some understanding about the rules under which nursing homes operate—including the facility's corporate requirements, as well as federal and state requirements—if they hope to effectively represent the residents' interests. Similarly, the more the provider understands the purposes of and the rules governing the LTCOP, the more effectively he or she will communicate with the ombudsman.

Successful ombudsman programs include training and education of staff, volunteers and others about nursing homes and other aspects of long term care. Providers should similarly be educated about the LTCOP. Seminars for staff or presentations to administrators and other avenues for clarifying roles will help to set the context for future interactions.

What the Provider Can Do

From my view as a former state ombudsman, the most significant barrier to effective communication with providers was a lack of understanding by the provider of the statutory role of the LTCOP, particularly as it relates to complaint investigation and resolution. Among the common complaints made by providers were:

- "Why does the ombudsman always represent the interests of the resident, why doesn't he or she represent me?"

- "Why does the ombudsman always come to me with complaints and problems instead of talking about the good things we do?"

- "Why is the ombudsman handling this matter; shouldn't the department of health investigate complaints?"

- "Why is the ombudsman in my facility on a regular basis; shouldn't ombudsmen come in only when they've actually received a complaint?"

- "Why didn't the ombudsman bring the matter to my attention instead of going to the licensing and certification office?"

These are valid and important questions and their answers lie within the statutory and conceptual framework of the program. The LTCOP is to investigate and resolve complaints *made by* or *on behalf* of older individuals who are residents of long term care facilities and this is the program's primary business. Since the enactment of the LTCOP provisions in the Older Americans Act, many states have enacted their own ombudsman statutes, which build upon and further define the complaint investigation and resolution role of the program.

Complaint handling, particularly when it is an official capacity, is not often conducive to a warm reception. By its nature, the ombudsman's function is based on problems, some of which are extremely sensitive, difficult to resolve and, in some instances, involve a great deal of trauma and pain for the affected parties. It is therefore crucial that the complaint handling function be understood and accepted as the responsibility of the ombudsman.

The Ombudsman's Role

Few ombudsmen would disagree that they do not emphasize the positive enough, that they focus mostly on complaints and problems—it is the nature of their day-to-day work. My perception as the state ombudsman was that we wanted to point out the positive as well, but the reality of our daily work significantly limited the capacity to do so.

Nonetheless, ombudsmen do recognize the creative, sensitive and good work of providers. I have seen numerous examples of ombudsmen taking the time to write letters to the local media citing the particularly innovative and thoughtful practices of facility owners and administrators, taking part in special events honoring residents and including articles about positive actions of providers in program publications.

Confidentiality requirements often prohibit the ombudsman from discussing the complainant's problem with *anyone* outside the ombudsman program, unless a formal consent is obtained. In addition, insofar as it is possible, ombudsmen are guided by the wishes of the resident they represent. In some cases, the ombudsman may be convinced that the easiest and most appropriate way to solve a particular problem may be to immediately discuss it with the facility administrator, however the resident must give the consent to do so. Similarly, the ombudsman cannot disclose the resident's (or complainant's) identity to the licensing authorities without a written consent.

Two unique features of the LTCOP are the broad range of complaints and issues it responds to and the focus upon the individual resident's rights and entitlements. By visiting facilities on a regular basis, ombudsmen become better acquainted with staff and residents, which creates an excellent opportunity for good communications. By frequent interaction with ombudsmen, residents are more likely to understand their role and confide their concerns to an independent party. In addition, the regular presence of an ombudsman may assist in identifying potential problems before they become serious, as well as enable the ombudsman to better understand the day-to-day difficulties and realities of providers.

Recognizing Operational Boundaries

Communication between ombudsman and provider can be strengthened by recognizing that ombudsmen respond to problems resulting from actions by a variety of parties, other than the provider, that adversely affect the "health, safety, welfare and rights" of the resident. Examples include adverse actions by licensing authorities, placement agencies, public guardians and public entitlement agencies such as Medicaid.

This broad jurisdiction of the LTCOP, in contrast to licensing authorities which generally are limited to investigating complaints related to more specific regulations, provides an important basis for working with providers on many issues of mutual concern.

In fact, providers may want to arrange a meeting with their ombudsman to identify issues that have the potential for joint actions or attention. Also, providers may find it useful to turn to the ombudsman for assistance in resolving problems faced by their residents. I recall a situation that involved a guardian who had not paid the nursing home bill for several months, was not sending funds for the resident's personal use and had not visited the resident. After futile attempts to contact the guardian, the administrator turned to the ombudsman stating that the facility was being forced to consider eviction of the resident, an action he did not want to take. The local ombudsman wrote to the guardian, who was an attorney, stating that he was failing to discharge his duty and that this could lead to the ombudsman filing a complaint with the court of jurisdiction over the appointment of guardianship and, in this case, to the ethics committee of the state bar association. Payment from the guardian swiftly followed.

Adverse decisions affecting a resident's Medicaid eligibility or coverage are frequent causes for administrators filing complaints with an ombudsman on behalf of a resident. There is one note of caution to be heeded however: The administrator should guard against having it appear that the ombudsman is being asked to perform the facility's social service responsibilities.

Both ombudsman and providers should seek to maintain a relationship based on understanding and respect for each other's commitment to do their jobs well within the boundaries of their respective roles and responsibilities. Every interaction should be approached from the perspective that it is only one of what may be many discussions about a particular matter or future issues.

It should be remembered that the advocacy role of the ombudsman does inherently include the potential for an adversarial relationship in some cases. If a conflict cannot be resolved satisfactorily through negotiation from the resident's point of view (or the facility's or other parties to the dispute), then it may escalate into another arena in the effort to seek successful resolution.

Some complaints investigated by ombudsmen may require an automatic referral to enforcement or other legal entities. While these types of complaints are in the minority, they are included in each LTCOP caseload. These considerations notwithstanding, respecting each other professionally should enable ombudsman *and* provider to maintain effective communications.

Ombudsmen and providers are best served by avoiding broad generalizations about each other's role and about the sources of residents' problems. I was pleased to read in the May 1985 issue of the **American Health Care Association Journal** a comment by AHCA's Steven Press that providers "are not going to make progress in our relationship with consumers if we emphasize only the issue of reimbursement; nor will we succeed if we duck the issues of access to and quality of care." Too often, ombudsmen hear, as a response to issues they have raised with an administrator, "we can't really do anything about this because the reimbursement rate is too low." While current reimbursement rates in a particular state may impose real limitations, this cannot serve as an automatic reason for not being able to resolve significant issues which adversely affect residents.

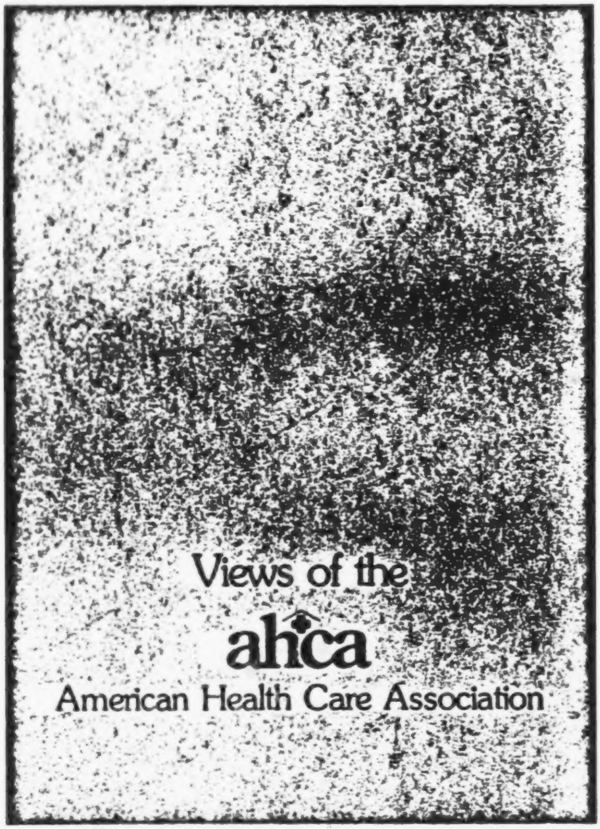
Mutual Sensitivity in Word and Deed

Of course, effective communications are not enhanced when ombudsmen and other advocates make gratuitous remarks about nursing home profits or that nursing homes should not exist. Similarly, good provider/ombudsman relations are not helped when providers make similar remarks about volunteers or advocates in general. I once shared the podium with a provider who said that nursing home advocates "follow the grant money and when their sources of funding dry up, they'll be gone." The audience was a large group of administrators.

Nursing home providers, ombudsmen and other consumer advocates are serious about their responsibilities and wish to be treated with professional respect and courtesy. It is easy for all of us to cloud our perceptions by our own sense of how others ought to behave; we expect others to realize how committed we are and how difficult *our* job really is. While complaints and criticisms are far easier to give than to receive, they are a necessary part of the checks and balances necessary to pursuing the highest quality of care and full respect for the rights of residents, on whose behalf we are all working.

Providers and ombudsmen alike must work within certain defined boundaries, hierarchies and bureaucracies and these conditions greatly affect our abilities to meet the expectations of others. However these limitations can be overcome and conflicts resolved when respect and understanding for all participants are present. Good communication between providers and advocates may not be crucial to the resolution of all problems, but it certainly can make the process easier, both now and in the future. ■

AHCA Statement on Long Term Care Ombudsman Program



Views of the

ahca

American Health Care Association

AHCA Statement on Long Term Care Ombudsman Program

Introduction

The American Health Care Association (AHCA) is a non-profit association representing nearly 8,000 licensed nursing homes and allied long term care facilities throughout the nation. AHCA recognizes the potential benefits of programs, such as the Long Term Care Ombudsman Program, that seek to enhance the well being of long term care facility residents, and supports the concept of such programs. We believe that both Quality of Life and Quality of Care must be emphasized and enhanced in the delivery of long term care. We also believe that programs that increase the involvement of the community in lives of older individuals in facilities and other settings, who might otherwise become friendless and become isolated, can provide an invaluable contribution toward improving the lives of such individuals.

However, in observing the implementation of the LTC Ombudsman Program over the past several years, AHCA has identified issues that we believe call for statutory changes or other clarification of Congressional intent. We addressed many of these issues in our comments on the implementing regulations emphasizing the need for clarification and more specific guidance in the regulations. Nevertheless, the final regulations closely follow statutory language, thus providing little clarification. AHCA believes that the changes in the statutory and regulatory framework that we recommend are necessary to make the program more effective, to avoid unnecessary problems and to fulfill original program objectives.

We think it important to state that the

Administration on Aging Program Instruction (AoA-PI-81-8, January 19, 1981) and existing chapters of its Guidance Manual for State Programs[1] address many of these issues in a satisfactory manner. However, neither of these documents have the weight of law; they are merely advisory in nature. We therefore think it essential that certain major issues be addressed by the Congress when it considers reauthorization of the program. Additionally, while recognizing the benefits of avoiding unnecessary regulation, we believe that regulations should address and clarify certain issues that may not be appropriately addressed by legislation.

We will discuss our concerns and member's experiences with the program in general terms and conclude with specific recommendations for Congressional action.

General Discussion

AHCA believes that the scope of the program should be expanded to include all services for older adults. As home care and other community based programs continue to grow, the assistance of the long term care ombudsman will become increasingly important to elderly individuals receiving these services. We urge that Congress consider such expansions in a fiscally responsible manner, being mindful of the relationship between financial resources and program scope and ability to function effectively.

Qualifications of the state long term care ombudsman are of particular concern. AoA (Sec. E. 5.) has addressed this issue. Our members' experiences[2] have demonstrated that a well qualified individual is essential for program success; individuals who have not had adequate experience and do not understand the complexity of issues involved have often created more problems than they have solved.

Experience has also shown that involvement of providers in all aspects of program development and implementation is another important factor in program success. We believe that advisory groups that include providers should be required to ensure dialogue about major policy issues.

In considering other basic issues, it is important to realize that many of the concepts and problems being discussed have complex interrelationships and cannot be resolved separately.

One basic issue is the need for recognition of the rights of providers and their responsibility to provide care and protection to their residents. AoA (Sec. G.6.b) has recognized this; we are convinced that understanding of this issues by the state ombudsman is a critical element, especially in the area of complaint investigation and resolution.

Facilities' rights include the right to carry on the activity of providing care without undue interference or harrassment as well as recognition of their due process rights, such as the right not to be unfairly accused of wrongdoing and the right of the "accused" to present information on its behalf. These matters have not been adequately addressed in federal law, regulations or AoA documents. Provision should also be made for resolution of legitimate provider complaints about the behavior of specific ombudsman representatives.

Access issues have three major components: access to the facility, access to the individual resident and access to personal and medical records of residents. The issue of access to facilities raises questions of the purpose and time of the visit, areas of the facility open to the ombudsman representative and permitted activities. We believe facility access during normal business hours is generally sufficient and access other than during normal visiting hours should be permitted only under unusual circumstances, for which a standard should be defined.

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[1] Throughout this document, statements such as "AoA emphasises ... or AoA states ..." with section citations will be references to the 1981 Program Insturction. "Manual" refers to existing chapters of the Guidance Manual.

[2] In developing these comments, AHCA obtained information on program implementation from many of its affilaited state associations. Some of this information is referenced in this document; a summary is appended.

When access to individual residents is considered, questions such as (1) whether such access may only be in response to a specific complaint or when the ombudsman representative has otherwise obtained the residents' name, (2) the mental and physical condition of the resident and (3) the degree of privacy required are raised.

AHCA has developed a policy statement on access, which appears on page 12. It is recommended for Congressional consideration. In general, we believe that reasonable access by representatives of community organizations is beneficial to long term care facility residents. However, we also believe that such access must necessarily be limited by and balanced with other considerations, such as the facility's responsibility to provide protection to its residents, residents' rights to privacy, the physical capacity of the facility and the schedule of facility and resident activities.

Access to personal and medical records raises questions of confidentiality, the qualifications of those reviewing the records, residents' rights of privacy, conflicts with state law and the burden on the facility. While we believe that resident (or guardian) permission for access to specific records should be required and that general access to records should be permitted only by obtaining a court order, by referral to the state licensing agency or by individuals with medical training, we believe that state law should control this issue.

Use of contractors (Sec. C) and development of substate (local) units, including citizens organizations (Sec. F), to perform ombudsman program functions raises serious questions. While AoA forbids, because of potential conflicts of interest, use of organizations or agencies such as state licensing or certifying agencies or organizations in any way associated with long term care facilities, it does not recognize that certain advocacy or union-related organizations might also have conflicts of interest that would prevent their "vigorous and *impartial*" (emphasis added) implementation of the program (Sec. A). Characteristics and permitted functions of "community organizations" and contractors should be specified; the role of advocacy or union-related organizations having a definite conflict of interest can thus be given reasonable limitations, by prohibiting certain activities by these groups. In addition to basing the ombudsman program in the state aging unit, there should be clear prohibition against contracting major functions to organizations or state government units with potential conflicts of interest.

Our survey indicated that volunteers qualifications, roles, required training and supervision are additional major factors in program sucess. AoA's manual addresses these issues appropriately and thoroughly. However, the qualifications and role of individuals providing training should also be identified.

We find the complaint system, described in detail by AoA (Sec. G), to be conceptually reasonable. However, implementation of this activity has created problems in several states. One major problem has been the failure to provide a mechanism for response by the person (individual, facility, organization or agency) whose action has been the cause of a complaint. It would seem that such a provision should be added; in addition to protecting the due process rights of those involved, it would assure adequate investigation of the complaint. One state affiliate reports that providers are not informed of complaints nor given opportunity to respond; they have been told that protection of complainant confidentiality requires this. We disagree. In general, we do not believe that complaints can be adequately investigated or resolved unless the provider is informed and involved. The "Complaint Management Issues" chapter of the AoA Manual supports our viewpoint, in addition to discussing those situations in which confidentiality considerations do not permit provider involvement. We also believe that providers should receive some documentation of complaint resolution.

Other problems regarding the complaint system have been reported by some state affiliates. Some ombudsman programs do not act upon complaints submitted by facility representatives about other organizations or agencies or do not act upon complaints that are not *about* long term care facilities. AoA has clearly stated that facility staff may make complaints (Sec. D.2) and that acts of "... government or quasi-governmental agency, which may affect in an adverse way the health, health-related, financial, social and other services provided ..." are included. Ombudsman programs should specifically be required to accept complaints lodged by providers on behalf of their clients and residents. AHCA believes that cooperative efforts of LTC ombudsman and providers are the most desirable mechanism for assisting elderly recipients of LTC services in resolution of their problems. Because states were permitted to develop programs incrementally, limiting the kinds of complaints to be acted upon in the early stages of development of an ombudsman program may have been justified; a fully developed program should not have such limitations.

Complaint resolution involves "translating the results of the investigator into beneficial action on behalf of the complainant/resident" (Sec. G.5). AoA identified six means of problem resolution, ranging from persuasion to encouraging legal action. It indicated that all reasonable avenues of complaint resolution should be exhausted, while recognizing that some complaints cannot be resolved to the satisfaction of the complainant. Follow-up and monitoring activities, as appropriate, are also identified as part of the complaint resolution process. Our state affiliates indicate that the extent to which the ombudsman program refers complaints and their resolution and follow-up to other appropriate state agencies is also a factor in the success of the program. For example, patient care issues related directly to state licensure requirements are often best resolved by that agency. AoA (Sec. G.6.e.) strongly recommends such referrals.

Establishment of a uniform reporting system that includes collection and analysis of data, with reports submitted to the Commissioner of AoA, the state licensure agency and other appropriate public agencies, is another requirement that has presented problems. To a great extent, these problems are related to the way in which data has been presented, particularly categorization of types of complaints, verification of complaints and evaluation of the satisfactoriness of complaint resolution. Categorization of type of complaint raises problems if the seriousness of the complaint, as well as the subject matter is not indicated. For example, lack of sufficient amounts of nutritional food and absence of an individual's favorite foods fit into the same subject matter category but are not equally serious in nature.

If, in the case of a complaint about lack of favorite food, investigation revealed that the patient's medical regime did not permit use of the food and that after repeated explanations, the patient refused to accept this dietary limitation, the complaint would probably be classified as a verified complaint with unsatisfactory resolution. Without further explanation or subcategorization, such information could be interpreted to reflect negatively on the long term care facility. AoA provided general guidelines for both the reporting system (Sec. I) and the Ombudsman's Annual Report (Sec. J). The Manual addresses these concerns in greater detail.

We are aware that, in many cases, the lack of sufficient qualified staff within the state agency has been the primary cause of reporting problems. However the possibility of information being presented so as to justify the existence of the ombudsman program and show the need for additional or continued state financial resources for the program is a factor that cannot be ignored.

Another major group of substantive issues is related to the use of volunteers and citizen organizations. While the law mandates both their participation in the program and the training of volunteers, it gives no indication as to the permissible scope of activity, volunteer qualifications or levels of training required. AoA appears to expect most volunteer activity to take place at the substate organizational level (Sec. F, 2-4). Training requirements, covered in one paragraph (Sec. L), indicate that persons with complaint investigation and resolution responsibilities must receive training ". . . in the amount and frequency necessary . . .". Training in access to records and confidentiality issues is specified (Sec. G.6.d.v). In reviewing training materials developed by state ombudsman programs, as well as AoA's information on training, we have identified several satisfactory programs. They include information about relevant state and federal laws, financial issues, the aging process, the long term health care system and available resources, as well as giving extensive training in effective and impartial complaint investigation and resolution techniques. Again, the Manual addresses these issues in some detail, including subjects such as reimbursing volunteers for expenses and screening, as well as specific training recommendations.

We also believe that community education and visitation programs in facilities, as developed by many state ombudsman programs, have great value and should be given more emphasis by all programs.

Specific Recommendations

Before making specific recommendations, AHCA would like to go on record as recognizing the value and professionalism of AoA's guidance materials. We believe AoA should be allocated sufficient resources to complete the Manual in a timely manner, while maintaining the quality of existing chapters, so as to provide continued guidance to state programs. We deplore the fact that federal budgetary considerations have resulted in a decrease in the number of staff persons, as well as the resources available to them, for performance of these important functions.

The first recommendation is that Congress address key issues in the statutory language. We suggest that the following items, discussed in detail above, be included in legislation:

- Expansion of the program to include all services for older adults.
- Development of a state-level advisory body that includes provider representation. Existing advisory groups dealing with aging issues (such as a State Commission on Aging) should be permitted to provide this function.
- Protection of provider due process rights in the complaint resolution process. At a minimum, providers should be able to file a statement as part of the official record and should be informed of the final outcome.
- Prohibition against unions, union

related organizations or other organizations having a definite conflict of interest performing local ombudsman functions.

- Delegation of authority on confidentiality of and access to medical records questions to state law.
- Requirement that complaints from providers be received and acted upon.
- Requirement that state ombudsman program be based in state aging unit and not contract major functions to organizations or state government units with potential conflict of interest.

The second recommendation is that the Congress instruct AoA, Office of Human Development Services, to develop regulations that are sufficiently detailed so as to give guidance on major issues not addressed in the legislation. We suggest that the following items should be included in regulations:

- Minimum qualifications for the state ombudsman.
- Limitation on access to facility by volunteers to a reasonable (to be defined) standard.
- Minimum standards for volunteer training.
- Encouragement, without any prohibitions, that the expertise of other state agencies, such as the state licensure agency, especially in complaint resolution and education, be utilized.
- Requirement that confidentiality constraints (to be defined) apply to all aspects of unresolved complaints.

In summary, our observation and analysis of the program since its inception have enabled us to identify elements that are characteristic of successful state programs. They include precise delineation of program purpose, procedures and practices; a highly qualified state ombudsman; a reasonable approach to sensitive issues such as privacy of medical records and access to facilities; well trained volunteers and opportunity for meaningful provider involvement in program development and implementation.

Because AHCA believes that the Long Term Care Ombudsman Program has the potential to benefit older individuals receiving a variety of services, including services in long term care facilities, we strongly recommend that Congress take necesary action to ensure the effectiveness, objectivity and professionalism that are necessary for the program to achieve this potential.

Note: Much of the information upon which this document is based was obtained by surveying AHCA's state affiliates. Information about the survey content, process, analysis and follow up is available from AHCA upon request.

Public Access to Patients in Long Term Care Facilities

This position statement outlines AHCA's views on public access to patients in long term care facilities. This document was approved by the AHCA Executive Board and ratified by the Governing Council.

The American Health Care Association is the nation's largest federation of nursing homes and allied long term health care facilities. Its 8,000 facility members care for more than 650,000 residents.

The paper is intended to raise issues for consideration, as well as guidance, for member facilities as they develop their own policies in the areas of access. Balancing the need for privacy and freedom of communication for individual residents and facility responsibilities to all residents within the facility is the focus of the paper. Specific policy guidelines are presented for consideration by individual facilities.

Public Access to Patients in Long Term Care Facilities

The American Health Care Association (AHCA) has developed the following position for consideration by long term care facilities. As a non-profit association whose membership serves over 650,000 persons in 8,000 facilities in 48 states, AHCA is vitally concerned with the well being of all nursing home patients. This concern extends not only to the physical needs of patients, but equally to those mental or social needs which have a direct bearing on their physical progress and prognosis.

AHCA believes that the patient's total mental and social needs are beyond the capacity of any individual facility to meet in their entirety and that a life, free of a feeling of isolation and loneliness, requires interaction with and support from the community outside the facility. The community consists not only of family and friends, but for persons or groups whose desire is to serve the "whole patient" for the benefit of the patient.

Based upon this belief, AHCA recommends that long term care facilities develop and implement access policy guidelines which can be used to encourage as much interaction with the community as possible.

Such a policy must ensure, at the same time, that the facility can properly discharge its responsibilities to the patient including protecting the patient from unwanted intrusion into his privacy or possible abuse by individuals or groups who may wish to use the patients' needs to further their own end. AHCA encourages that such policy guidelines be in a written form which is suitable for distribution to patients, their families, community organizations, and other persons or groups who may desire to visit the facility and whose visitation may benefit the patient.

Rights of Patients

AHCA believes that patients in long term care facilities have the right to private and unrestricted communication with family, friends, and other persons with whom the patient wishes to speak, absent documented medical direction to the contrary. Implicit in this is the patient's right to voice grievances and recommend changes in policy and services to the facility residents council and/or grievance committee as well as to persons outside the facility, free from restraint or interference by facility staff or personnel.

Co-equal with the right of private and unrestricted communication is the patient's right of privacy. AHCA does not believe that individuals or groups should be permitted access to an individual patient, in the patient's room, without prior permission of that patient. To permit visitors to wander through the halls of a facility, entering patients' rooms at will and without permission, is to deny their right to treatment with dignity and individuality.

Much of the daily care of patients involves physical therapy, medical examinations and treatment, and assistance in performing personal functions. At such times, the appearance at the patient's door of unexpected and unknown visitors is frequently unsettling and may represent to the patient a clear invasion of his privacy. Absent the patient's consent, persons not directly involved in the patient's care and treatment should not be allowed to enter or remain in the patient's room.

To balance the patient's right to private communication with his right to privacy, AHCA suggests the following policy guidelines for consideration by individual facilities:

Scheduling Guidelines

Visitors who are unknown to patients should schedule visits at least one day in advance. By prior scheduling, visitors can insure that no conflicts will arise with other scheduled activities, and the facility can inform patients in advance of visitors to the common areas who will be available to discuss topics of interest to patients.

AHCA suggests that visitors inform the facility in advance of the size of the visiting group. In this way, the facility can arrange for the availability of common areas if desired by the visitors. All visits should be scheduled within the facility's customary visiting hours.

Visitation Guidelines

All visitors entering a facility should promptly notify authorized facility personnel of their presence. Upon the request of the facility, visitors should produce appropriate identification. For representatives of community and other organizations, the wearing of name tags throughout the visit may prove useful to patient and facility alike.

Visitors not present at the request of a specific patient should be permitted access to the common areas of the facility, and may be accompanied by staff personnel to and from these common areas. Visits to a patient's room are appropriate only when the patient has consented to the visitation. In the event that a patient's physician has advised against visitation, as documented in the medical record, then visitors should be so informed and should not be permitted to communicate with that patient while in the facility.

All discussions with patients in the facility's common area should be private and unrestricted. Absent the specific request of a patient, facility personnel should not remain present during individual discussions, nor otherwise interfere with or intrude upon such communications.

Individuals or groups desiring to visit with a patient should be permitted to do so only with the permission of that patient. The appropriate staff member should notify the patient of the visitor's presence and if the visitor is not known to the patient the subject matter which the visitor wishes to discuss with the patient. If the patient consents to the visit, the visitor should be shown to the patient's room by the staff member. Although facility personnel may then accompany visitors on their departure from the patient's room, they should not remain present during the visit unless so requested by the patient.

All visitors to long term care facilities are responsible for conducting themselves in a courteous and respectful manner. No one visit, for example, should be prolonged so that it tires the patient or disturbs or tires his roommate. The patient retains the absolute right to terminate the visit at any time and for any reason, and his right should be respected.

In the interest of ensuring that staff may perform their normal duties and functions without interruption, visitors should not request staff assistance or make demands on staff time unless absolutely necessary. Suggestions regarding the facility's operation, care of patients, and similar matters should be brought to the attention of the facility administrator. Visitors should depart promptly at the end of visiting hours, so that patient care routines may be observed.

Facilities are responsible for safeguarding the privacy, security, and safety of their patients with regard to visitation. The facility should respect the rights of patients who do not wish to receive visitors. During visits, patients should not be subject to photographing, filming, videotaping or audiotaping unless they have consented to these activities. In addition, the facility may not release or discuss information in a patient's medical record unless it has first obtained proper, written consent as required by laws.

Because of the facility's responsibility to its patients, the Administrator may refuse access to any person if he has reason to believe that a visit by this person would be injurious to the health, safety or security of patients. However, such a refusal must be properly documented. In addition, he should refuse access to persons seeking entrance for commercial purposes.

Long term care facilities have an important responsibility to ensure that a patient's right to privacy and his right to private communication are respected. AHCA believes that the foregoing guidelines achieve a needed balance between these rights, and urges its facilities to incorporate these suggestions into written visitation policies.

American Health Care Association
Questionnaire
Long Term Care Ombudsman Program
State Implementation
January, 1983

State: 27 Responses

Instructions: Please answer the following questions about your state's implementation of the federally mandated long-term care ombudsman program. In most cases, "yes," "no," or other one word answers are sufficient. However, please feel free to add additional information you believe is important. Additionally, please send the documents identified in question 14 only if you believe they illustrate important points or unusual characteristics (desirable or undesirable) of the ombudsman program in your state.

1. How long has the long term care ombudsman program been operating in your state? Most — 7 years (response to federal mandate)

2. How many individuals have held the office of state LTC ombudsman during that time? From 1-5. There appears to be a correlation between high turnover and provider dissatisfaction.

3. Does the current state ombudsman have a background in (a) health 3rd (b) aging 2nd (c) social work Most common (d) other (describe) Some law. Only one or two without relevant experience, with high provider dissatisfaction in these states.

4. How many of each of the following are statewide? (a) paid staff Most often 1-2 (b) volunteers From 0-several 100 (see question 10).

5. Is the program authorized by (a) state statute? 13 (b) regulations(only)? 2 (c) operating (or other) guidelines (only)? 4 (d) other (specify) Federal law and regulations.

   In general, there was high dissatisfaction in states operating only under federal law and regulation, apparently because state laws and regulations clarified many "open" and troublesome issues.

6. Where is the state LTC ombudsman office based? (e.g., governor's office, division of aging, health department) 3 private, 1 governor's office, most division or commission on aging.

7. (a) Are there local (county or regional) offices? 20 yes
   (b) If yes, where are they based? Planning districts, counties, some only in large metropolitan areas.

8. (a) Is there a state advisory council? 10 yes, several planned or part of other advisory group (b) Are LTC providers represented? 8 yes

9. (a) Are there local advisory councils? 11 yes
(b) Are LTC providers represented? 10 yes

10. (a) Has the volunteer component of the program been implemented? 18 yes

(b) Do volunteers function as (1) visitors 15 (2) inspectors 7 (3) trainers 3 (4) other 10 (advocates) (c) Are providers involved in volunteer training? 8 yes, 5 qualified yes.

11. Are other community groups (e.g., nursing home reform groups, legal services, area agencies on aging) involved in program implementation? (Describe briefly) 23 yes, legal services and AAAs most common.

12. Will ombudsman accept complaints about resident's problems from providers as well as complaints about providers? One no, but 5 "yes" were qualified. For example, in some states it depends on the local ombudsman representative; in others, the kind of complaint is the deciding factor.

13. Please indicate your overall assessment of the following aspects of the program as implemented in your state.

	Assessment			
Item	Satisfactory	Neutral	Unsatisfactory	Comments
(a). Objectivity (impartially) of ombudsman and ombudsman representatives	15	4	6	
(b). Access to facility	17	3	5	
(c). Access to patients	17	3	4	
(d). Access to records	15	3	7	
(e). Training of volunteers	5	9	8	
(f). Working with provider to resolve complaints	16	3	6	
(g). Opportunity for provider to submit as part of record, information regarding complaints	17	4	4	
(h). Ability to resolve complaints	12	8	6	
(i). Working relationship with state survey/ licensure agency	12	8	5	
(j). Working relationship with provider groups	14	7	4	
(k). Ombudsman's knowledge of LTC	12	5	7	
(l). Adequacy of volunteer training programs	3	9	10	
(m). Confidentiality of ombudsman records (including complaints)	14	6	5	

Other comments Many of above answers were qualified. Following is a discussion of responses to each item:

a) Objectivity
Materials submitted generally demonstrated impartiality (or lack of impartiality) of the ombudsman. For example, in states where ombudsman materials emphasized well being of residents (as opposed to "badness" of nursing homes) and public education, objectivity of program representatives was rated "satisfactory".

b) Access to Facility
Identification of ombudsman representatives and hours of access were the main issues cited. Identification includes use of identification cards for ombudsman representatives and the representative identifying him/herself to the administrator (or his designee) when entering the facility. Of the three issues, failure of the representative to identify himself appears to have caused the most problems.

c) Access to Patients
In general, this has been a problem only when facility access has been a problem.

d) Access to Records
Providers expressed concerns about unqualified individuals examining records, especially when state law requirements appear to conflict with ombudsman program representative access rules. The potential for provider liability, as custodian of the record, and for misinterpretation or misuse by individuals who are not adequately trained appears to be a major factor.

e) Training of Volunteers
See (1) below.

f) Working with provider to resolve complaints
"Unsatisfactory" responses cited accusatory approaches, failure to investigate complaints fully and lack of knowledge of the ombudsman representative as reasons for dissatisfaction. Materials submitted were quite specific about the importance of this factor for programs rated as "satisfactory".

g) Opportunity for provider to submit information
While this has generally not been a problem, providers in states where it has been are most vocal in their opposition to the program.

h) Ability to resolve complaints
Many respondents perceived the program as generally ineffectual; in some cases poor "networking" with other resources, including other state agencies and provider organizations, was identified as the cause.

i) Working relationship with state agencies
Programs rated as effective and otherwise satisfactory tended to also be rated "satisfactory" for this characteristic.

j) Working relationship with provider groups

j) Working relationship with provider groups
Most respondents recognized their responsibility in this area; some described the often difficult process in developing a good relationship. Programs rated as "unsatisfactory" appear to give little or no opportunity for provider input in any aspect of the program.

k) Ombudsman's knowledge of LTC
The importance of this factor for both state and local (paid staff) ombudsman representatives cannot be overlooked. One highly positive response described the state ombudsman as "a strong advocate, but highly competent, knowledgeable and fair". On the other hand, most negative responses included complaints about the ombudsman's qualifications. Both education and experience were cited.

l) Volunteer training
As can be seen from the responses, this is a major issue. Most states had volunteer training programs, but few were rated as "satisfactory". In reviewing materials submitted, important factors include the number of hours of training, breadth of training program (subjects included), qualifications and diversity of trainers (inclusion of providers, nurses, state surveyors, etc.), assessment of the effectiveness of the training (testing) and inclusion of field work (facility visits).

A relationship between volunteer functions and the need for training was also apparent (i.e. training requirements for friendly visiting and complaint investigation need not be the same).

m) Confidentiality of records
In general, problems appear to be related to inadequate or conflicting procedures and giving information about unresolved complaints to the press.

14. Please send documents indicated below (please see instructions):

	Status	(Please check or indicate date, as appropriate)	
State Ombudsman Document	Enclosed	Will send on (date)	Does not exist or is not useful for survey
(a). State law			
(b). State regulations			
(c). Guidelines			
(d). Executive order			
(e). Operations manual			
(f). Most recent annual report			
(g). Volunteer training manual			
(h). Other			

Note: Most respondents sent some documents. Material was also received from states for which a survey response was not obtained.

Completed by:

Name ______________________________
Title ______________________________
Organization ______________________________
Address ______________________________
____
Date ________________
Phone (for follow-up purposes) ________________

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Mr. **Wyden**. Thank you very much, and particularly for your speed. Both of you have moved vigorously.

Ms. Holder, it's always a pleasure to have you with us. We'll make a prepared copy of your remarks a part of the record. We would appreciate it if you, too, could highlight some of your concerns.

STATEMENT OF ELMA L. HOLDER, EXECUTIVE DIRECTOR, NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

Ms. **Holder**. The creative formation of the Ombudsman Program largely through the vision and efforts of Dr. Flemming, and the resulting national ombudsman network, have now begun to fulfill the critical needs of citizens in our country's long-term care facilities. At this very moment we can be sure that scores of ombudsman are with residents and their family members helping them resolve some of the diverse problems which concern them.

Many States have adopted legislation which help protect residents based on the experiences, information, and insights of Ombudsman and Advocacy Programs. Also, the development of Federal laws and regulations is more reality based because of the ombudsman's information.

The program has contributed greatly to the health, welfare, and civil rights of residents, and therefore, to nursing home reform. Its accomplishments are chronicled in State annual reports and the few annual summaries of the Administration on Aging.

Besides its strengths, I was asked to address some of the program's weaknesses, which I will, in order to direct attention to its needs and mobilize support to meet them. I must emphasize that these weaknesses result more from problems in the long-term care system than from the current structure or service delivery of the programs.

What are some of the problems? There are individuals serving as ombudsmen who do not have the training they need in order to be most effective and responsible. As stated in prior testimony, they recognize the need and want such training.

There are certainly existing programs which tend to serve the nursing homes, administrators, and staff better than they serve the residents. As it happens in some State regulatory agencies, an overriding focus of the program can become helping, cajoling, consulting with, or assisting, administrators and staff to get them to do a better job. This in itself is not bad or wrong, but because of limited resources this often results in less access for the residents to the ombudsman, and less time to identify and resolve individual's problems.

There are some programs which at times operate in a manner counter to the efforts of the State regulatory agencies. This is necessary when the State agency does not enforce standards, but most often this happens when there are misunderstandings and poor communication. It's a two-way problem.

These problems and/or weaknesses are all real and are generally known to the ombudsman. They are also understandable given the poor support for this important public health program; since they are understandable they can also be overcome.

It has been noted that the Administration on Aging has responsibility to provide support to the network. If AOA did provide or would arrange to have provided the assistance needed, the many weaknesses, and the gaps and inconsistencies among program, would not exist. Although never sufficient in amount or scope, in the past AOA did provide a variety of services to the Ombudsman Program.

As Dr. Flemming indicated, AOA did provide central office staff support, and issue grants and contracts to other organizations to uphold the program. For example, our own organization was granted funds from 1979 to 1981 to develop and maintain an information clearinghouse for the State and local programs, as well as for citizen advocacy groups. Several other organizations received regional contracts to provide assistance and training to the Ombudsman and Legal Services Programs.

By 1981 significant advancements had been made by these groups to develop and deliver the needed support. However, AOA's advocacy initiatives for all practical purposes ceased that year. All of these groups, including our own, attempted to obtain new grants from AOA to continue these coordinated efforts. We were not successful.

Until 1981 AOA had also been in the forefront of Federal agencies advocating for an improved regulatory system to protect nursing home residents. This leadership, central to its responsibilities, fell by the wayside by 1982. AOA did not replace the backup services with other backup programs, nor did it increase its services from the central office. In fact, it moved the opposite direction. It began to resist attempts and often put roadblocks in front of the remaining AOA staff person who continued to attempt to assist the programs. Staff efforts to provide an assessment guide to the Ombudsman Program, to disseminate helpful information, to develop and disseminate a summary report of ombudsman activities, and to issue a completed report of the national training conference held last fall, were all greatly reduced, resisted, diluted, or stopped.

In earlier testimony today an AOA representative talked about current support for the program. We join others in applauding any support AOA has or will now provide; however, a clear tracking of the record would, in my opinion, reveal that AOA has provided support only reluctantly.

This record is documented in the official grievance that Sue Wheaton, the former staff person for the program, filed against AOA based on her transfer out of the Ombudsman Program this year.

In addition to the constant prodding of Ms. Wheaton, I believe that it is the great needs of residents in nursing homes, and the resulting needs and public pressure of the mostly isolated Ombudsman Programs—which currently drive AOA to action after recent years of program neglect. AOA needs support and help to move forward, but its efforts should also be monitored carefully to assure new support emerges that is based on the actual needs and involvement of the ombudsman.

We have a lot of work left to assure the dreams of the Arthur Flemmings and others are realized, and to achieve the success Congress surely must have intended when it made the program an integral part of the Older Americans Act.

As others have stated here today, there is a dire need to budget sufficient financial support. At the current budget level we expend surely less than $1 per long-term care resident per year for this program which is vital to the health and well-being of those residents.

From a national budgetary perspective, additions of small moneys, say, even $10 per resident per year, could help assure the success of the program.

I thank you for the opportunity to express my comments and will answer questions if needed.

[The prepared statement of Ms. Holder follows:]

TESTIMONY OF ELMA L. HOLDER, EXECUTIVE DIRECTOR, NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

The creative formation of the ombudsman program in 1971, largely through the vision and efforts of Dr. Arthur Flemming, Ruth Knee, a former HEW official, and others, and the resulting national network has now begun to help fulfill the critical needs of older (and younger) citizens in our country's long-term care facilities.

At this very moment, as we sit together discussing this important program, we can be assured that scores of local and state ombudsmen (both paid staff and volunteers) are with long-term care residents and/or their family members, helping them resolve some of the diverse, often complicated problems which concern them. These problems range from providing assistance in getting better meals or activities services, to obtaining needed medical assistance, to helping residents obtain needed public benefits, to assistance with complicated neglect and abuse cases.

Many states have adopted legislation and regulations which help protect the residents, based on the experiences, information and insights of local and state ombudsman and advocacy programs. Additionally, the development of federal laws and regulations has been more reality-based because of the information from ombudsman programs.

In many states, the ombudsman network has provided extensive public educational programs regarding the long-term care system, and the needs and rights of citizens living in long-term care facilities.

The ombudsman program has contributed greatly to the health, welfare and civil rights of long-term care residents and; therefore, to nursing home reform. Its accomplishments, too many to mention here, are chronicled in numerous required state annual reports and the few annual summaries of state activities produced by the Administration on Aging.

Besides its strengths, I have been asked to address some of the programs' weaknesses, which I will gladly do, in order to direct attention to its needs and to mobilize support to meet such needs. I must emphasize that the weaknesses I present result more from problems in the long-term care system itself, than from the current structure or service delivery of the actual programs in the field.

What are some of the problems?

(1) There are individuals serving as ombudsmen and their volunteer assistants who do not, in fact, have the training they need in order to be most effective and responsible. As has been stated here before me, they recognize the need and want such training.

(2) As in any other field, there are ombudsmen at the state and local level who are not suited for their role because they lack sufficient qualifications or experience or may not be of the best temperament for the job. Clearly, the provision of more and better training programs could take care of some of these individuals' problems. The emergence of the National Association of State Long Term Care Ombudsman Programs is evidence of the desire of ombudsmen to upgrade their skills and to give support to each other in their professional roles.

(3) There are certainly existing programs which tend to serve the nursing homes, their administrators and staff, better than they serve the residents who live there. As it happens in some state regulatory agencies, a major, sometimes overriding focus of the program becomes helping, cajoling, consulting with, or assisting administrators and staff to get them to do a better job. This, in itself, is not bad or wrong. However, because of the limited resources of the ombudsman programs, this often

results in less access for the residents to the ombudsman, and less time for the ombudsman to identify individual's problems and to advocate for problem resolution.

(4) There are programs, both state and local, which sometimes operate in a manner that is counter to efforts of the state regulatory agencies. Sometimes this is necessary when the state agency is not doing its job of enforcing standards, but most often this happens when there are misunderstandings and lack of communication between the ombudsman programs and the state regulatory agencies. It's a two-way problem.

These problems or weaknesses are all real, and they are generally known to the ombudsman network. They are also understandable—given the lack of support for this important public health/social services program. Since they are understandable, they can be overcome.

It has been noted that the Administration on Aging has responsibilities to provide service and support to the ombudsman network. This should be clear to anyone who understands the related provisions of the Older Americans Act. If AoA did provide—or would arrange to have provided—the assistance needed by the program, we would not have the many weaknesses, nor the gaps and inconsistencies which exist among the state and local programs. Although never sufficient in the amount or scope, in the past AoA did provide back-up services to this program.

AoA provided central office staff support and issued grants and contracts to other organizations to uphold this program. For example, our own organization, NCCNHR, was granted funds from 1979-1981 to develop and maintain an Information Clearinghouse for the state and local programs, as well as for the network of citizen advocacy groups. Several other organizations, including the National Senior Citizens Law Center, the Legal Counsel for the Elderly of the American Association of Retired Persons, the Center for the Public Interest, and the University of Michigan Gerontology Program, as well as others, were given special bi-regional contracts to provide technical assistance and training to the ombudsman and legal services programs. By 1981, significant advancements had been made by these groups to develop and deliver the needed support; however, AoA's advocacy initiatives, for all practical purposes, ceased by 1981. All of these groups, including our own, attempted to obtain new grants from AoA to continue these coordinated efforts; we were not successful. Until 1981-82, AoA had also been in the forefront of federal agencies advocating for an improved regulatory system to protect nursing home residents. This leadership from AoA, central to its responsibilities under the Older Americans Act, also fell by the wayside by 1982.

AoA did not replace the back-up services noted above with other back-up programs or by increasing its services from the central office. In fact, it moved in the opposite direction. It began to resist attempts and often put roadblocks in front of the remaining staff person, Sue Wheaton, when she continued to attempt to assist the programs. Her efforts to provide an assessment guide for the ombudsman program; to disseminate specific information helpful to ombudsmen and their assistants; to develop and disseminate a national summary report of ombudsman activities (based on the state reports); and to issue a completed report of the national training conference held last fall were all greatly resisted, diluted or stopped. In earlier testimony today, an AoA representative presented information about current support for the program. We join others in applauding any support AoA has or will now provide; however, a clear tracking of the record would, in my opinion, reveal that AoA has provided support only reluctantly. This record is clearly documented in the official grievance that Sue Wheaton, the former staff support person for the ombudsman program, has filed with AoA, based on her transfer out of the ombudsman program this year.

I believe that it is the great need of residents in nursing homes for help, and the resulting great needs and public pleas of the now isolated state and local ombudsman programs which are currently driving AoA to action, after recent years of neglect of this program. AoA needs support and help to move forward, but its efforts should also be monitored carefully to assure that new support emerges and to assure that it is based on the actual needs and involvement of the ombudsmen themselves.

We have a lot of work left to do to assure that the dreams and plans of Arthur Flemming, Sue Wheaton, the ombudsmen and others are accomplished and to assure the success Congress surely must have in tended when it made the program an integral part of the older Americans Act. To start with, as others have stated here today, there is a dire need to budget sufficient financial support for the program. At the current budget support level, we expend about $1.00 per long-term care resident per year for this program which is vital to their health and well-being. From a national budgetary perspective, additions of small monies, say even $10 per resident per year, could help assure the success of the program. For when it reaches full maturity—when its ideals and objectives are accomplished, at least three important things will happen:

(1) All individual providers of long-term care—owners, operators and staff, and all state regulatory agencies and individual surveyors will welcome and fully understand the important role of the ombudsman program in assuring quality care. They will fully cooperate with this program.

(2) The community-at-large will be knowledgeable about the responsibilities of facilities and the rights of the residents, and will be intimately involved in helping local facilties mobilize and provide any services which will enrich the lives and care of the residents.

(3) The program will assure that every resident in every community long-term care facility has easy, regular access to a sensitive, well-trained advocate who can help them resolve any problems or assist them in obtaining answers to any technical questions they may have about their care, their entitlements, and their residency in a long-term care facility.

Given the express importance of the national long-term care ombudsman program to our current older population, and to we older people of the future, we have no alternative but to move forward and to all work together to provide the support that the program needs and deserves.

Thank you for the opportunity to share this information and to express my views. The National Citizens' Coalition for Nursing Home Reform stands ready, as always, to join in support for this program.

Mr. **Wyden**. Well, thanks very much, Ms. Holder, for a very valuable presentation.

Ms. Ferguson.

STATEMENT OF WILDA FERGUSON, COMMISSIONER, VIRGINIA DEPARTMENT ON AGING AND FIRST VICE PRESIDENT OF NATIONAL ASSOCIATION OF STATE UNITS ON AGING

Ms. **Ferguson**. Thank you, Mr. Chairman. I am happier than I thought I would be to be here this morning as the Commissioner of the Virginia Department for the Aging, to assure you that, yes, indeed, the Commonwealth does have an Ombudsman Program. It is alive and well, and growing.

I also am pleased to be here to present the comments of the National Association of State Units on Aging. These comments are on the important contributions of the State Long-Term-Care Ombudsman Program in advocating on behalf of the most vulnerable segment of our older population; namely, the institutionalized elderly.

The State Long-Term-Care Ombudsman Program is an integral component of both the service mandate and the advocacy mandate to State units on aging. We are proud of the effective implementation of this program by State governments. The act appropriately holds the State units on aging accountable for assuring that the State Long-Term-Care Ombudsman Program achieves its statutory objectives, regardless of where that Ombudsman Program is placed in State government.

The structure is different in many States, but this diversity does help to create programs which are more responsive to the needs of older persons, and which allows the states to take advantage of unique opportunities and circumstances to enhance program development.

Like other aspects of the Older Americans Act, the State Long-Term-Care Ombudsman Program encompasses both direct services and advocacy. The program develops a service of individualized advocacy on behalf of residents of long-term care facilities. It establishes a system of investigating and attempting to resolve complaints from individual residents. In carrying out this role not only have ombudsmen been able to assist individuals, but they have also been able to analyze trends in individual complaints which may highlight needed changes in State statute and legislation.

This information feeds into the second aspect of the program. It serves an advocate for policy changes which will benefit all residents of long-term care facilities.

As part of State government, State units on aging, and State Long-Term-Care Ombudsman Programs have access to information, support, policy analysis, and contacts with other relevant State officials, which enhance their roles as internal advocates. They have unique opportunities to influence State long-term-care policies through the preparation of policy analysis serving on State interagency task forces, developing legislative packages for consideration by Governors, and providing information on current policy issues through state newsletters and other communication vehicles.

From NASUA's perspective we do believe that there are ways to strengthen individual State programs. Our experience has taught us that one of the most effective ways to enhance State program capacity is to systemically exchange information on program strategies across State lines. In this manner states can build upon the successes of their peers across the country, and can learn about potential problems which could be avoided.

We've heard a lot this morning about things that are wrong. I'm pleased to be able to say NASUA is beginning to take a stand to help correct some of those things.

In January of this year the NASUA board decided to convene all State ombudsmen and legal service developers in conjunction with the 1986 NASUA membership meeting. The NASUA committee on elder rights is in the process now of soliciting suggestions from State ombudsmen on topics which they would like to have addressed at this meeting.

NAUSA is also in the process of seeking public and private resources to provide specialized technical assistance and support to State long-term-care ombudsmen.

As part of this effort we intend to collect and disseminate information on program design, to collect model training curriculum, and training manuals used by States for both paid staff and volunteers, to identify effective systems of reporting documentation, particularly those that are automated, and provide information and assistance in areas such as liability, conflict of interest, relationship with the industry, and volunteer management, and to collect and analyze State legislation in such areas as enabling legislation, patients bills of rights, and program access.

We believe that sharing of information on State legislation is particularly important. Each State Ombudsman Program exists within a unique context of State laws and regulations affecting the operation of long-term care facilities. As a result, many Sates have specialized state statutes addressing the Ombudsman Program. Through the exchange of information on such statutes the States can identify legislative provisions which could be revised to fit their own special circumstances in order to strengthen the operation of the program, and to enhance the rights and benefits of older persons.

I thank you for the opportunity to make these comments, and will be glad to answer any question.

[The prepared statement of Ms. Ferguson follows:]

Prepared Statement of Wilda Ferguson, Commissioner, Virginia Department on Aging, and First Vice President of NASUA

Mr. Chairman and Members of the Committee: I am Wilda Ferguson, Commissioner of the Virginia Department on Aging and First Vice President of the National Association of State Units on Aging. I am pleased to present the comments of the Association on the important contribution of the State Long Term Care Ombudsman Program in advocating on behalf of the most vulnerable segment of older Americans, namely the institutionalized elderly.

NASUA is a national public interest organization which provides information, assistance and professional development support to its members, the nation's 57 State Units on Aging. The Association provides an organized channel for state leadership in aging to exchange information and mutual experiences and to join together for appropriate action on behalf of the elderly.

From its beginning, the Older Americans Act has been designed to enhance the independence and dignity of older people and to protect their rights and benefits. Two major strategies are incorporated in the Act for achieving those objectives. First, the Act funds a range of programs and services designed to assist vulnerable older people. Secondly, the Act explicitly addresses the mission of the aging network to serve as visible advocates on behalf of the elderly. The State Long Term Care Ombudsman Program is an integral component of both the service mandate and the advocacy mandate of State Units on Aging.

We are proud of the effective and efficient implementation of this program by state governments. The Act appropriately holds the state Units on Aging accountable for assuring that the state long term care ombudsman program achieves its statutory objectives regardless of where the ombudsman program is placed in state government.

Across the country, the organizational structure of the program varies. Some states have centralized ombudsman programs operating at the state level; others have established local programs through the area agencies or other entities. In most states the program is administered by the State Unit on Aging and is deeply rooted in the aging network; in several states the program has been delegated to another agency. Some states have significant participation of volunteers; others rely primarily on paid staff. In addition some states use "hot lines" or toll free lines to facilitate access to the program.

As with other programs under the Older Americans Act, the flexibility provided to states in designing program strategies has resulted in a multitude of structures. We believe that this diversity has helped to create programs which are more responsive to the needs of older people and which allows states to take advantage of unique opportunities and circumstances to enhance porgram effectiveness.

Like other aspects of the Older Americans Act, the State Long Term Care Ombudsman Program encompasses both direct services and advocacy. The program provides the service of individualized advocacy on behalf of residents of long term care facilities. It establishes a system for investigating and attempting to resolve complaints from individual residents. In carrying out this role, not only have ombudsman been able to assist individuals, but they have also been able to analyze trends in individual complaints which may highlight needed changes in state laws and regulations.

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As part of state government, State Units on Aging and state long term care ombudsmen have access to information, reports, policy analyses and contacts with other relevant state officials which enhance their role as internal advocates. There are unique opportunities to influence state long term care policies through the preparation of policy analyses, serving on state interagency task forces, developing legislative packages for consideration by the Governor, and providing information on current policy issues through state newsletters and other communication vehicles.

From NASUA's perspective we believe that there are ways to strengthen individual state programs. Our experience has taught us that one of the most effective ways to enhance state program capacity is to systematically exchange information on program strategies across state lines. In this manner states can build upon the successes of their peers across the country and can learn about potential problems which could be avoided.

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NASUA is also in the process of seeking public and private resources to provide specialized technical assistance and support to state long term care ombudsman. As part of this effort we intend to: collect and disseminate information on program design; collect model training curriculum and training manuals used by states for both paid staff and volunteers; identify effective systems of report documentation, particularly those that are automated; provide information and assistance in areas such as liability, conflict of interest, relationships with the industry, and volunteer management; collect and analyze state legislation in areas such as enabling legislation, patient bills of rights, and program access.

We believe that sharing of information on state legislation is particularly important. Each state ombudsman program exists within a unique context of state laws and regulations affecting the operation of long term care facilities. As a result many states have specialized state statutes addressing the ombudsman program. Through the exchange of information on such statutues, states can identify legislative provisions which could be revised to fit their special circumstances in order to strengthen the operation of the program and to enhance the rights and benefits of older people.

Thank you for asking us to present our perspective on this critical state program. We applaud the Committee's continuing commitment to improving programs which enhance the well-being of older Americans.

Mr. WYDEN. Well, thank you all for an excellent presentation. If there were time, I would take a considerable amount of time for questions, but time is short I just wanted to catch up on a couple of things.

Ms. Trocchio, you said something that struck me as just incredible, and that is the Congress needs to instruct AOA to produce a manual of instructions? We've had this program for 10 years and the association says either that it's not out, or—I'm not quite sure. If you mean complete a manual of instruction, it strikes me as an incredible failure on the part of the Administration on Aging to not have a manual out as to how this program should operate after 10 years.

Is there nothing out in terms of information? Or is this a question of updating something? Maybe you could go into that a little more?

Ms. TROCCHIO. There is a program instruction that has been filling in some of the gaps that the legislation and the regulations do not address. It's our belief that what has come out so far is just excellent. It has filled in a lot of the gaps, and has led to great improvement in the program; however, that manual is incomplete. I believe that work on it has stopped, and that no plans are underway to either complete that, or another document which is a self-evaluation of the substate units. We encourage both documents being completed.

Mr. WYDEN. At least there's some information out there that people can turn to. I perhaps was under the impression that there was absolutely nothing out there. We've heard so much about discretion, I thought to myself, you know, goodness, do you just kind of make this up as we go along.

But you feel what you've got is excellent, and you just need more, and it needs to be updated?

Ms. TROCCHIO. That's correct. And we've appreciated the opportunity for our association to comment on it as it's been developed.

Mr. WYDEN. OK.

The question, Mr. Varpness, about the A-122 circular is a point that I think you make, and make well. Chairman Biaggi has had a great interest in this, and I think you know that it's the view of the subcommittee that you're right on this point. The A-122 circular really could, in a lot of ways, directly interfere with the mandate to the Older Americans Act, particularly this section, to advocate for older people which can be done only if Circular A-122 doesn't, in effect, negate the ability of advocates to come forward and make changes.

So we welcome your views on that, and are going to follow up.

Ms. Holder, as well, your point about additional suggestions for the staff, I think, will be helpful. You and other witnesses are going to have some additional questions. I share a lot of your concerns in these areas. It's very consistent with what Dr. Flemming said as well. You saw in 1981 a whole variety of things were put in motion. Then all of a sudden they just seem to trail off into the vapor and we don't know what happened to them. So we're going to followup on your recommendations as well.

Ms. Ferguson, in reference to your point about the State units on aging, and their convening an arrangement to share information, and serve as a clearinghouse, I think that's very welcome. We're glad to have that assistance. Suffice it to say that should have been done directly for these programs a long time ago; it shouldn't have had to fall upon the state units on aging. But clearly we are in this fight together and in the effort to strengthen these programs, the State units are going to be most helpful, and most welcome in their participation.

With the House adjourning, if there are no further comments or questions, we will leave the record open, I believe, for 2 weeks. The staff will have additional questions for these panel members, and I believe others. If there are no further comments, we will stand adjourned.

The hearing is adjourned.

[Whereupon, at 12 p.m. the hearing was adjourned.]

APPENDIX

LOUISVILLE, KY, *October 1, 1985.*

BENTE EWALDSEN COONEY,
Research Assistant, Subcommittee on Human Services, Select Committee on Aging, Washington, DC.

DEAR MS. COONEY: Please incorporate the following comments into the record for the hearing held on September 10 relating to the Long-Term Care Ombudsman Program:

1. INDEPENDENCE OF THE PROGRAM

The Ombudsman Program created under the Older Americans Act should be administratively separate from the agency administering the Medicaid program. This would serve to insulate the Ombudsman from political and internal pressure within the administering agency. I cannot understand how any ombudsman program buried in the same system that regulates and pays for nursing homes can have the necessary independence to be advocates for the elderly under the existing law. Clearer guidance is needed from the Administration on Aging and its regional offices in this area.

2. FUNDING

The funding for the Ombudsman Program is totally inadequate. The Commonwealth of Kentucky spent over $200 million through the Medicaid Program last year on nursing home care, yet we allocate only 1% of Title III B money to assure our tax dollars are buying quality care. A large number of nursing home residents have no family members to monitor their care and therefore must rely on the Ombudsman Program. The regulatory agencies that are supposed to assure quality care only look at the facilities compliance with minimal licensure regulations that have no real relationship to quality care. The Ombudsman must fill the gap left by licensure personnel and ensure residents are receiving adequate care on a personal basis.

3. EXPANSION OF OMBUDSMAN ROLE INTO HOME HEALTH CARE

There are now over 14,000 residents in Kentucky nursing homes. Any expansion of the Ombudsman's present responsibilities would only serve to weaken the already over burdened program. Also, great care should be taken to avoid a possible conflict of interest since the Ombudsman Program is funded with Title III funds as are many of the home care and home health care programs in part.

If I can be of further assistance, please contact me.

Sincerely,

Representative GERTA BENDL,
34th District, Jefferson County.

PREPARED STATEMENT OF JILL C. DUSON, ESQ., LONG-TERM-CARE OMBUDSMAN, MAINE COMMITTEE ON AGING

These comments are respectfully submitted in response to an invitation from the Chairman of the Subcommittee on Human Services.

THE STRUCTURE OF THE LTCOP/MCOA

In Maine, the Long Term Care Ombudsman Program (LTCOP) has been administered by the Maine Committee on Aging (MCoA) since its inception as one of the original Ombudsman Demonstration Programs in 1975. The MCoA is an independent citizen advisory board. Its membership is appointed by the Governor, to advise the Executive Branch, the Legislature, and all state agencies on issues pertinent to Maine's elderly.

The Committee is statutorily empowered to serve as advocate and ombudsman for older people. To carry out this function, state law gives the Committee broad powers to enter any nursing, boarding, or adult foster care facility, speak privately with any individual therein, and inspect and copy all records (with the consent of the resident) pertaining to a resident held by a facility. Thus, the LTCOP in this state was originally intentionally modeled to be operationally independent of the state unit on aging, which is part of the Department of Human Services. The Ombudsman Program has found its placement within the MCoA to be most advantageous in two key areas.

1. Legislative advocacy

As a citizen advisory committee, the MCoA mandate includes direct access to our states legislative leadership. The LTCOP is therefore able to advocate for the inclusion of long term care issues into the biannual legislative agenda of the Committee, and to offer our special expertise as a resource to the Legislative Committees through which long term care related measures must pass.

2. Administrative advocacy

Its placement outside of the state departmental/bureau structure gives the LTCOP the capacity to utilize the Administrative Procedures Act (APA) process to focus attention on state regulatory issues which adversely impact on long term care consumers.

THE ISSUE OF LTCOP INDEPENDENCE

As the Committee is aware, the Older American's Act (OAA) specifies four broad areas of activities for the state Long Term Care Ombudsman Program.

(i) Complaint Handling
(ii) Legislative Advocacy
(iii) Administrative Advocacy
(iv) Volunteer Training and Citizen Involvement

The complaint handling process is by its nature crisis oriented and a major portion of ombudsman resources is devoted to this area. In my experience as a long term care advocate, I have found that it is far too easy to get bogged down in the flow of complaints and lose sight of the need to step back and do issue oriented advocacy. It is clear from the OAA mandate that the Program's designers anticipated the development of a broad based approach to improving the quality of long term care consumers. Ombudsman program services should go far beyond the simplistic application of "band-aid" resolutions to repetitive complaints. Program structure and priorities should foster a realization that the receipt of a number of complaints regarding bed hold policies for Medicaid residents of nursing homes may equal an issue. Long range planning strategies should be utilized to develop and implement specific action steps for gaining a change in regulations or law to resolve the specific problem for the original complaints and other long term care consumers. While quality complaint handling, volunteer training, and citizen involvement are the foundation of a strong LTCOP, it is the degree of focus on achieving incremental systematic changes which are the true measure of its abilities to meet the broad mandate outlined in the OAA.

Advocacy within the administrative and legislative forums are the tools for achieving broad based change. However, the ability of individual ombudsman programs to effectively utilize these tools can be dependent on its placement within the network of aging advocates. For example, the Maine program enjoys access to the decision makers in the legislative and rule making areas because of its position within the MCoA. In contrast, placement within the state unit on aging would superimpose at least five layers of supervisors between LTCOP and those whom within the state system may submit proposed law. In addition, in the area of administrative rule making, the LTCOP if housed within the state unit on aging, would be limited to internal advocacy with that unit's sister bureau, which surveys and licenses facilities and administers the Medicaid Program within our Department of Human Services. Finally, the LTCOP if housed with the state unit on aging would have to complete with the nutrition, outreach, care management, social services, and other state unit programs for attention to the issues of its virtually invisible constituency.

The physicial location of the LTCOP within or outside the state unit on aging is not the issue upon which our attention should be focused. The more important necessity is the development of a set of standard program features which maximize the programs ability and visiability as the focus of advocacy for long term care consumers, regardless of its placement. For example, the designated state Ombudsman should have direct access to the state unit on aging's Director. That simple adjustment would greatly stengthen many state programs where the Ombudsman is buried under multiple levels of supervisory structure. The Director of Maine's state unit on aging was in important actor in the design of this State's independent LTCOP and also played a key role in the activities which lead to the formal incorporation of the Program into the OAA. The model has worked will for Maine, largely due to the ongoing strong relationship between the Bureau of Maine's Elderly and the Maine Committee on Aging. However, even when housed within a consumer advisory board such as the MCoA, the Ombudsman Program must compete for attention with a variety of issues which arise out of the Committee's mandate to advocate for all elderly.

The invitation to submit written testimony posed the question "Would the Ombudsman Program be more effective if it was set up as an independent agency?" This question poses a third alternative, to which I had not previously given much thought. Assuming that I were trying to design the strongest possible model for a LTCOP, would I choose:

(1) Placement within the state unit;
(2) A subcontract from the state unit on aging to another entity; or
(3) Direct funding to an independent agency?

I feel strongly that the current status of the Maine LTCOP within the Committee and the skills of the individual who served as Ombudsman for seven years, have been the two catalysts in development of the extraordinary quality of ombudsman services in our State. Thus, I mean no disservice to our current structure when I state that my strong preference is for the eventual evolution or the Ombudsman Program as an independent agency. To my knowledge, there is no such totally independent program in existence. However, this question prompted me to recall the structure of an organization known as Pennsylvania Advocates for Better Care (PABC). This organization was also one of the original ombudsman demonstration projects. It was, however, set up as an independent agency with a separate Board of Directors, and its sole focus was long term care advocacy. I became familiar with PABC as a young attorney responsible for developing a nursing home advocacy project supported by Foundation Funding, and housed within a local legal services corporation program.

The PABC provided our fledgling project with training in volunteer recruitment and retention, community organizing, issue advocacy, fund raising, etc. It is based on my experience with this group that I endorse the independent agency model. It should be noted, however, that PABC was closed down due to lack of funding after years of functioning on a shoestring, constantly digging for private sources of operation monies.

Given the current climate within the political arena and the aging network, I have little expectation that the reintroduction of this third model will fly. More realistically, it is clear that we who enjoy some degree of independence must pull together with the majority of ombudsman programs which are currently housed within the state units on aging to improve our capabilities as a profession, and to advocate for ourselves and our constituency at the state and national levels.

PROGRAMMATIC NEEDS OF THE STATE LONG TERM CARE OMBUDSMAN

The activities which NASUA proposed to undertake on behalf of Ombudsman are meritible in that they respond to a portion of the laundry list of programmatic needs which we enumerated for the AOA as participants in the national training meeting which AOA sponsored.

At that meeting, held in November, 1984, state ombudsman proposed that the role of the AOA Ombudsman liaison position be strengthened and redefined to provide direct access to the Commissioner on Aging, several additional staff, and the performance of the following specific functions:

Act as national advocate for the Ombudsman Program.

Development of a national clearinghouse on long term care issues.

Provision of technical assistance, consultative services, and training.

Coordination of state efforts to identify, address and implement local strategies to coincide with national efforts on broad issues.

Facilitation of annual ombudsman training meetings.

Consolidation of annual LTCOP reports and development of a national analysis and report.

Development of training curriculum on the role of the regional office liaison person vis a vis the LTCOP.

Coordination of regional office monitoring procedure to ensure intra regional consistency.

Assist regional office liaison staff in facilitating the development of regional training meetings.

Development of a national newsletter.

Data collection and analysis of long term care issues.

Issuance of action alerts and bulletins.

Periodic update and distribution of a LTCOP personnel directory.

Periodic revision of the Technical Assistance Manual.

Timely issuance of program instructions relating to LTCOP annual report requirements.

In my opinion, it should be the AOA which first addresses this ombudsman with list. AOA (hopefully with imput from Ombudsman) must review its commitment to the LTCOP and specify whether that commitment will be implemented internally or via contract to an outside entity. At that juncture any number of qualified organizations, including but not limited to NASUA, may submit proposals for review. It is through this process which the ombudsman themselves will have the best opportunity to play a formal role in the development of programs to address our needs. In addition, this process will hopefully lead the AOA, NASUA, and other entities who profess National Association of State Long Term Care Ombudsman Programs (SLTCOP).

ADVOCACY ASSISTANCE PROGRAM,
Denver, CO, September 25, 1985.

Representative MARIO BIAGGI,
Chairman, Select Committee on Aging, Subcommittee on Human Services, Washington, DC.

DEAR REPRESENTATIVE BIAGGI, Thank you for the opportunity to submit written testimony on the Long Term Care Ombudsman Program.

I have served as the State Ombudsman in Colorado for five and a half years. As an advocate for the rights of residents of long term care facilities, I am also an advocate for the Ombudsman program which attempts to fulfill a critical need, a consumer presence for the most vulnerable, defenseless disabled population. The main job I see for the Ombudsman is making the systems work for residents.

The most significant program issues, as I see them, are underfunding, responsibility without authority and program independence. Additionally there is a problem nationwide regarding information and technical assistance for the State Ombudsman programs.

The issues are all interrelated. Funding for the State program has remained at a minimum level, although the wording "effective" was added. Responsibility of the State program is to have local programs, yet the wording of the Older American's Act, is for the Area Agencies to "carry out programs in support of", has not been sufficient to motivate Area Agencies on Aging without a state mandate. The Ombudsman program is required by law to investigate complaints in long term care facilities yet access to the facilities has not been provided. States are supposed to obtain access to the Ombudsman, but this is often at legislation whim. The program was given the added responsibility but no authority for handling personal care boarding home complaints. In many states these homes are unlicensed or unknown.

Ombudsman are often up against a highly organized industry. There is virtually no power of the market place in the hands of the real consumer. A unique characteristic of the nursing home system is that, for the most part, it is the government who is the payer.

In Colorado, the Ombudsman program is located with a private, non-profit organization. This avoids limitations on program activities and conflicts of interest.

The other identified problem is the need for information sharing between the State Ombudsman programs and technical assistance from a central office. This service is currently absent from the Administration on Aging. The Regional offices are not well enough informed to provide assistance.

Given these identified problems, my recommendations are as follows:

(1) Legislation which provides authority and access for the state program and mandates the Ombudsman program as a priority service for the Area Agencies on Aging.

(2) Increased funding—potentially a percentage from the Medicaid program.

(3) Legislative direction to Health Care Financing Administration to raise patients rights to a "condition" of participation.

(4) Independent agency for the Ombudsman program.

(5) $100,000 to be spent as follows: $1,000 to each state for electronic mail equipment; 50,000 to establish a central clearing house, bulletin board function; funding for the clearing house function to be ongoing.

Enclosed is a recent letter of mine for your interest. Again, thank you for this opportunity.

Sincerely,

VIRGINIA FRASER,
Long Term Care Ombudsman.

[From the Denver Post, April 1985]

NOT GETTING WHAT WE PAY FOR

(By Virginia Fraser)

As the State long-term care ombudsman—a consumer representative for residents of nursing homes and other long-term care facilities, my role is to be objective, analytical, concilatory, a problem solver, a mediator.

Last week I got tired of all that. A reflection in one of Edward Abby's books struck a responsive chord: "If I regret anything, it is my good behavior. What demon possessed me that I behaved so well?"

It may be time not to behave so well. My fantasy has produced all sorts of outrageous acts such as capturing the corporate owners of nursing homes and confining them in their facility for six months.

Here's how I came to this point. Our office handles complaints made by, for and on behalf of nursing home residents. Here is a sample of the issues this week from residents and family members:

"The food is barely fit to eat. Last night it looked like they mixed all the leftovers together and served it like hash. We got a half a piece of bread, which had dried out, and some greasy margarine."

"I'm so tired of going to the home and finding my father lying in urine-soaked clothes."

"If I dare to ask for help, the aides ignore me and the nurses snap at me."

"My mother had to go to the hospital, and a day later we were told by the hospital the nursing home wouldn't take her back. She thought it was her home."

"My oxygen bill went up 250 percent for the same usage when the new corporation took over."

"The hot water is so cold, no one can take a bath."

The complaints seem to be coming from homes where large, out-of-state corporations have recently taken over—firms with shiny-shoed, pin-striped businessmen who can barely tolerate consumer concerns.

They're not, however, the only ones I'd like to pick on. There are the legislators bored with people's concerns, who readily acquiesce to special interest but can't pass legislation to give the ombudsman program access to nursing-home residents.

This week I'm just tired of being fair. I know people have to make a profit; I know about all the health-care cost-containment issues; I know what a tough job running a nursing home is. But I wonder whether the corporate folks can really identify with what it's like not to ever have fresh fruit and vegetables. Can Senator X imagine what it would be like not to be able to go to the bathroom when he needed to?

It can't be only the duty of the Health Department to see that serious conditions in nursing homes are remedied. As it is, their resources are strained to the maximum, and they do a conscientious job.

I try not to bring more bad publicity to nursing homes; they get enough. The papers seldom tell the stories of caring staffs or recognize tough jobs. They haven't told the story of how one creative, caring owner has turned around a nursing home that could only be described as a tragic, pitiful dump. (We must support these positive moves. They show us that it's possible to provide good care and still make a profit.)

But I worry this week about corporate takeovers when vulnerable, dependent people are the product.

I worry about the effect of the new hospital "DRG" prospective payment plan under which persons are discharged earlier with more disability into nursing homes that may not be staffed or equipped to care for them.

I worry about the potential for discriminating against Medicaid residents (who make up 70 percent of the Colorado nursing-home population).

I worry about the decreased funding for adult social services and their lack of involvement with Medicaid clients in nursing homes.

I worry about the legislature making policy without really understanding nursing-home residents, problems and concerns.

I worry about increasing abuse by overworked, underpaid, untrained staff.

There are ways to address these issues.

There needs to be more hue and cry about the living—we have a duty to speak for the voiceless, an obligation to care for the defenseless. There needs to be a local advocacy system to assist residents and families in knowing what their rights are, to insist on quality care, to bring issues to the attention of policymakers, to make sure at a minimum that we, the public, get what we pay for.

PREPARED STATEMENT OF ESTHER E. HOUSER, STATE LONG-TERM-CARE OMBUDSMAN, OKLAHOMA

I am submitting this testimony to you to provide you with input from a State Long-Term Care Ombudsman who is housed in a State Unit on Aging and who finds the placement appropriate and fully supportive. It is my understanding that this is an area of interest to your study of the Ombudsman Program nationwide.

First, in a philosophic sense, it is appropriate to place the ombudsman advocacy function in a state agency or unit on aging (and at the substate level, in an area agencies on aging) due to these agencies' advocacy responsibility under the Older Americans Act. Wilda Ferguson, representing NASUA, presented this point thoroughly in her testimony to you on September 10, 1985. It is not of course, inappropriate for a state unit on aging to contract out for its statewide ombudsman program responsibilities. However, I would ask what advocacy role is played by state units on aging who do so. Does the placement of the ombudsman program outside the state and area agencies on aging assure independence of action, or force the re-creation of the wheel in aging service networks? Does it help or hinder further the already limited access which frail, isolated, institutionalized elders have to the "system" which should be available to help them—with more than just their complaints?

Older long-term care facility residents have many more needs than those an institution can satisfy. Many of these areas of need coincide with needs of community-based elders: transportation, eyeglasses, social enrichment, intergenerational contacts, to name a few. These are areas of need which clearly should or could be addressed by Older Americans Act funded programs. But there are states whose ombudsman complain of the lack of these most basic and non-threatening forms of cooperation from the state and area agencies on aging.

In Oklahoma, the State Ombudsman Program operates within the State Special Unit on Aging of the Department of Human Services. The eleven sub-state programs, with both paid staff and certified volunteers, operate within the Area Agencies on Aging. We believe this program to be both functional and effective. There has always been support for the ombudsman program within the Special Unit on Aging and a clear understanding that the entire aging network has an advocacy function. The Department of Human Services leadership supports and has defended the autonomy which any ombudsman program requires, and recently has established ombudsman positions in other aspects of its organizational structure.

Another factor contributing to what I regard as the success of Oklahoma's ombudsman program, is that the Area Agencies on Aging have received a clear and consistent message, from the state unit, that the program is important to the well-being of a significant part of the elderly population. That AAA involvement was required, and would be supported through on-going training and technical assistance, as well as financially, was an additional part of "the message" that should be noted. Although some AAAs were reticent at first to become actively involved in institutional advocacy, for a host of reasons, there is now strong support for ombudsman and other activities to benefit long-term care facility residents.

I have been asked by ombudsman, staff of your committee, and others if I felt that the success of Oklahoma's Ombudsman Program within the State Unit on Aging was due to the personalities involved, the structure, or other reasons. I have given this considerable thought, and recognize that the success of one program or the failure of another could be explained on the basis of personality (of the State Director, of the State Ombudsman, of the director of another agency in which the program might be placed, etc.), professional skills, understanding of the issues involved, political liabilities, financial considerations, or perhaps many other variables. Those areas do not remain constant anywhere, in any program, under any auspice. But a theme familiar to advocates for the institutionalized seems to me to emerge as a pattern in this issue, as well. Those common threads are enforcement and support, and those responsibilities lie with AoA. Unless AoA fulfills its obligations to the state ombudsman programs, we will find the same variability of program support and functional capacity as we currently see, regardless of the placement of the program.

The Administration on Aging's Region VI Office staff have been supportive and positive as an influence on Oklahoma's program. But AoA has never provided them with any substantial training with which to help us provide services to our clients. By the same token, this State Ombudsman received no training from AoA for years, during the most critical stages of the program's early development in the state. When AoA held it's National Training Conference for State Ombudsmen in November 1984, I had been State Ombudsman for nearly six years.

When problems arise for state ombudsman programs which signify lack of support by a state agency on aging, as some ombudsman report, there is no enforcement action—no sanction—by AoA. Vacancies may be left unfilled for extended time periods, travel may be restricted and some programs have reportedly failed for years to meet basic requirements of the Older Americans Act with no corrective action taken by AoA. With this basic unaddressed, changing the placement of the ombudsman program at the state level will hardly solve the problem of program integrity. With AoA giving no support to the program in any meaningful way, of course the success or failure of a state's ombudsman program depends on personal variables.

I have kept my comments narrowly confined to the issue of placement of state ombudsman programs. I feel that the variety of approaches found nationally is defensible, but that the State Units on Aging have a specific responsibility to directly support advocacy activities by and on behalf of all elders. Many other issues involved in ombudsman services are being addressed in your study and I am confident that the perspectives of ombudsmen were well presented by our representatives at your September 10 hearing.

Thank you for the opportunity to present this written testimony to supplement theirs. If you have questions about these comments, please contact me at Department of Human Services, Special Unit on Aging, P.O. Box 25352, Oklahoma City, OK 73125, telephone 405/521-2281.

ESTHER E. HOUSER,
State Long-Term-Care Ombudsman.

PRO SENIORS,
Cincinnati, OH, September 27, 1985.

MARIO BIAGGI,
Chairperson, House of Representatives, Select Committee on Aging, Washington, DC.

DEAR REPRESENTATIVE BIAGGI: In response to your invitation to submit testimony regarding the Nursing Home Ombudsman Program, I wish to offer for the committee's consideration a variety of observations.

Pro Seniors, Inc., of Cincinnati, Ohio is an advocacy agency for the elderly, funded primarily by the Area Agency on Aging and the local United Appeal campaign. As a private not-for-profit agency with a board of directors, we provide two services: The Legal Project for the Elderly and the Nursing Home Ombudsman Program. We serve a five-county area which has approximately 160 long-term care facilities with over 14,000 residents.

Our Nursing Home Ombudsman Progam has been in operation for 8 years and I have served as its director for six of those years. I currently serve as President of the Ohio Association of Regional Long-Term Care Ombudsman. It is from this experience that I wish to address my remarks.

When the federal government mandated the role of the Ombudsman, it created a program that was capable of miracles. In our State's development of local/regional programs, the power and influence was given to the local level to investigate and resolve the problems residents experienced. We created a corps of volunteers, official and unofficial, out of the hundreds of hours of trainings on nursing home issues we have provided in our communities. Our work in the development of Residents' Councils, our workshops for care-givers, our training sessions for families, volunteers, health-human service agency staff, have all left a legacy of informed lay people who were knowledgeable both about the issues and the mechanisms for problem resolution. We have attempted to make the plight of residents the concern and responsibility of all of us, not just the function of a few. In Ohio, the clear acknowledgement of our influence, in behalf of the consumer of services, is that the state or local Nursing Home Ombudsmen have served on nearly every committee created by a state agency regarding nursing home related issues for the past few years. The consumers' point of view is being heard.

While we are proud of our accomplishments, we experience demoralizing frustration. We have learned to speak legalese, medicalise and reimbursement systems. We have participated in investigations involving Medicaid fraud, patient abuse, the seizure of homes; we find ourselves out on a limb as a chronic condition. Yet technical assistance from the national Administration on Aging has deteriorated to the point of being non-existent. One truly has to wonder why it is that we have so little support from our "mother".

I can think of few publicly funded programs that have the capacity for so much healthful influence, one whose use of citizen/volunteers is extensive, while it at the same time gets so little in the way of assistance, financial and technical, on the federal level. Health care services are taking a greater bite than ever out of our tax dollar, yet we see little to show that the higher costs are going into more and better services for the beneficiaries of those services. Even without any humanitarian motives, the program would be and excellent investment on its ability to, from the consumers' point of view, make informed impact on state's reimbursement-related decisions.

With all due respect to our legislators, I must ask the wisdom of several things. First, without ever having sufficient funds to handle nursing home problems, we were mandated to also respond to Board and Care facility complaints. How were we to do that? Also, while our mandate is clear that we are to advocate in behalf of the institutionalized elderly, we are also under a federal mandate not to lobby for the class we seek to represent. While your invitation to respond was most welcome, it is offensive that we must wait to be asked in order to submit testimony. And it is equally offensive when writing grants for federal dollars to be told not to mention that we are an "advocacy agency", as if advocacy had become a dirty word.

If for no other than pragmatic reasons, since the cost of long-term care has threatened to bankrupt numerous states' Medicaid systems, please do what you can go get adequate support for our communities' efforts to be knowledgeable about and involved in insuring that our tax dollars are well spent for caring care, by assuring adequate support for the Nursing Home Ombudsman Program.

Thank you for your consideration and for this "legal" opportunity to speak.

Sincerely,

JACQUELYN KOENIG,
Nursing Home Ombudsman Program Director.

PREPARED STATEMENT OF ABRAHAM MONK, PH.D., PROFESSOR, COLUMBIA UNIVERSITY, NEW YORK, NY

Stringent controls and regulations were introduced in the last 15 years in response to the public outrage with nursing home conditions. Research, however, has given repeated evidence that ordinary regulatory procedures do not work well with services which have disabled powerless people as their clientele. Unless external monitoring is relentlessly exerted, the service provider may forego the primary imperative of high quality care and lean toward more immediate concerns for efficiency and profitability. Research has also pointed to a strong relationship between the rate of visitors to a nursing home and good care but since many nursing home residents do not have relatives or receive visitors very infrequently, a publicly sponsored ombudsman program is viewed as the only support left to which the residents may turn.

In a national study of the ombudsman program we conducted at Columbia University with grants from the Andrus Foundation of the AARP-NRTA, we examined the overall efficacy and most specially, the contribution made by volunteer ombudsmen. We found that the majority of the state programs reflect varying mixes of professionals and volunteers but the use of volunteers has remained a highly charged, controversial issue. As one respondent told us: "even very sympathetic administrators of mursing homes feel affronted when their professional integrity and 20 years of experience are questioned by a newcomer who never set foot in a nursing home before." State commissioners of human services and state ombudsmen were similarly concerned with the low level of skills of the volunteers in question. They wondered whether they could really make a dent in the system and felt they often take a confrontational stance, overlooking the importance of establishing working relations that are non adversarial. Nursing home residents told us however that this is one of the few programs where problems, once reported, get on the spot, immediate attention. Simple concerns such as patients with urine stained clothing, or those whose eyes and teeth examinations were neglected for years are resolved instantaneously. A volunteer ombudsman can be more of a confidant to the residents than any staff members. They build personal bridges even if at times they rely on incorrect technical facts and lack objectivity.

Professionals often told us that volunteers are not able to understand the complexities of the long term care system. Ombudsman volunteers are needed, however to be representative and supportive of a patient who might otherwise feel alone and helpless, not to deal with technical issues. They are there to advocate for better living conditions and to sound a voice of concern, to appeal, to ask and to insist. They should not be expected to master the operation of every service in place. True, some volunteers do not know how to properly handle complaints and may lack finesse in their relations with the nursing home's staff. Some are nothing more than glorified "friendly visitors." That in itself is not a loss or a symptom of program failure, because their presence makes the nursing home staff more responsive during those hours when they are present. Friendly visiting creates the kind of atmosphere which allows reticent elderly residents to speak up and unburden their hearts. Most interviewees in our study acknowledged that the volunteer ombudsmen are effective in matters of residents' rights and abuse problems. It is interesting to note that none of our respondents in the nursing home industry suggested to abolish the program. They admitted that it resulted in better staff-patients relations and eventually, in creating a better social climate in the institution. They insisted however that ombudsmen be confined to mediative, conflict resolution functions rather than to their advocacy stance. Other respondents—state commissioners and directors of human and health services, state ombudsmen, etc. felt that the presence of ombudsmen resulted in a heightened sense of accountability on the part of nursing home staff. We should not overlook a straightforward fact disclosed by our study: the galvanizing, even inspirational impact, of the volunteers altruistic and idealistic concern. However these attributes may play against such obstacles as institutional resistance, unbearable personal expenditures, lack of proper supervision and support, etc. They lead to a sense of isolation and rapid erosion of the idealistic motivation.

The following recommendations derived from our study are, in reality a synthesis of the comments elicited from our survey respondents (state and local government officials, nursing home administrators and personnel, community advocacy groups, volunteers and, or course, residents). Their selection reflects our own judgments:

1. We need to provide incentives for voluntaristic involvement of families, relatives and community groups, to counter the tendency toward excessive institutional rigidity and arbitrariness.

2. Legislation is needed to consolidate the right of access to all levels of institutional care. Ombudsmen should not be prevented from entering any long term care facility or approach the patients residing there.

3. Administrative sanctions should be given at the local level to voluntary sponsors. Central state authority should be retained in the state unit on aging, with formally defined linkages to all human and health service departments.

4. There is need to ensure that each state will operate an effective ombudsman network. Current policy provisions will allow too great a range of efforts, from exemplary programs to others that are little more than "paper tigers."

5. Volunteer ombudsman programs should underscore their generalist local function—that of detecting problems, eliciting information and initiating a redress process—but linked to the specialized back up expertise of professional staff.

6. Training of volunteer ombudsmen needs to be consequently enriched, in the understanding that ombudsmen are frontliners and that they do not intend to substitute for the professional staff of the state and local ombudsman units. They could still benefit from greater levels of preparation in licensing codes, entitlements, investigative procedures, negotiations and bargaining.

7. Volunteer ombudsman programs need to stress continuity of effort. Regularized rather than erratic visits to facilities will build trust, visibility and clarity of purpose needed to ensure success. Intensified outreach efforts should be aimed at the older, less educated and female residents. This is the population that feels most inhibited to voice their complaints and concerns.

8. The high level of stress and "burn-out" syndrome among these volunteers highlights the importance of a range of incentives continuously available to them. They should include rotating placements, a stipend program, peer group supports, retraining, volunteer career ladders and so on.

9. Community advisory boards are needed at the local level to ensure genuine sponsorship from all concerned parties. They should include adequate representation by long term care administrators and professionals, community service agencies, relatives and interested public at large.

Let me conclude by stating that the program under scrutiny is the only line of defense for many citizens living in closed environments and ordinarily lacking effective recourse over decisions affecting their lives. It makes no sense to stereotype staff and administrators of nursing homes as perennial scapegoats. Many of their actions are judicious and compassionate. Others, seen as arbitrary or unfair by nursing home residents, may well be the inevitable corollary of a high pressured environment, where workers must respond to a myriad of crises all at once. The merits of their actions is, however, less of an issue than the fact that they cannot be challenged. It does not take much for people who always led independent lives and are now suddenly confined to a regimented institution to feel helpless and in despair.

The ombudsman may be countering those negative feelings by restoring a measure of self-determination to their lives. It is their personalized approach to service delivery which distinguishes the ombudsman program from other quality assurance methods. Regulators, prosecutors and other law officers, although invested with considerable more authority, lack the capacity to maintain close, person-to-person connections with their clients at all times. The ombudsman's sensitivity to patient's needs, coupled with the direct and instantaneous feedback they provide, is what makes the program so unique and necessary.

Long-Term-Care Ombudsman Program
Mac Inc.,
Salisbury, MD, September 19, 1985.

Re: Expansion of the Ombudsman Program.

Select Committee on Aging,
Washington, DC.

Dear Sirs: I am pleased to have this opportunity to comment on the importance of the Ombudsman Program.

Enclosed please find two questionnaires completed by family members of nursing home residents showing the need for an Ombudsman Program.

The Long-Term Care Ombudsman Program of the Lower Eastern Shore of Maryland has been in existence since December 1979. We advocate for 1,553 residents in 15 facilities in a four county area. Enclosed are the statistics of complaints received and acted on from FY '80–'81 to FY '83–'84. Our fiscal year runs from October 1 to September 30. Since October 1, 1984 this program has received and acted on 221 complaints and 30 inquiries. This shows an increase every year and I suspect will continue to increase as more people become aware of the program.

If there is one problem that the Ombudsman Program has, it is lack of public awareness. Even though we are constantly trying to promote public awareness of the program, I feel there is a strong need for notoriety from the Administration on Aging as well as the State level. For the AOA and the State Office on Aging to give public support for the Ombudsman Program there would be more credibility of the program.

Thank you for your consideration in this matter.

Sincerely,

Mary Lou Mooney,
Program Director.

Enclosures.

[Enclosure 1]

(1) How much time did you have to decide on a nursing home?

Four months.

(2) Who did you talk with to get information on nursing homes?

I talked to the admissions Person/Social Worker and or Director of Nursing at about five different nursing homes. I didn't know that there were various agencies I could seek help from. I did go to the Department of Social Services to check on financial assistance.

(3) What information did you want and didn't get?

Having had no previous experience I did not know what questions to ask. Therefore, I only received the usual information that nursing homes give out.

(4) What information was most helpful in your decision?

My parent was in good physical condition but confused, completely ambulatory, very active and needed to be kept busy; therefore, one of the considerations was a busy activity schedule. I also checked for cleanliness of the home and the patients as well as for adequate help.

(5) Did you get too much or too little information?

Far too little because I did not know what questions to ask and whom to ask. I did inform Director of Nursing, upon original interview, of loved one's specific problem.

(6) Were you aware of the Ombudsman Program?

No.

(7) What information was your decision based on?

Visit to nursing home: Visited nursing home twice.

Recommendation. By one family.

Only bed available

Cost

Other (Please explain): See Question 10. I explain what other observations I would have made or action taken had I known then what I know now.

(8) If there was a service designated to meet your needs what would it look like? See attachment.

(9) Are you satisfied with your decision?

No. I think the key to families and patients being satisfied with the nursing home they select is to have prior information on which to base a wise decision. This information could be prepared and made available by the Commission on Aging.

What would help?

Publicizing that such information is available is important so that families anticipating nursing home placement can get it well in advance. Another important help would be for nursing home administration to see the need for participation of families or patients in the planning of the physical care and medical treatment of the patient. (See attachment) In fact, I think family participation is of paramount importance.

(10) Other.

See attachment.

[Attachment]

(8) A service administered by a person from the Commission on Aging who is more or less neutral and someone who could impartially dispense information about nursing homes to families to tell them what they need to know before they trust their loved one to such a home, especially if the loved one has a particular problem other than just general aging.

This person should be someone who could explain Patients' Bill of Rights and apply it to the patient's particular problem whatever that might be.

This person could organize a support group or compile a list of names of families who have already gone through the traumatic experience of placing a loved one in a nursing home. This list would consist of families who would be willing to give advice based on their experience.

This person could arrange for some type of referral service that could give psychological counseling to families if needed.

This person perhaps could arrange for the Ombudsman or nurse on Commission on Aging staff (if there is one) to sit in on Care Plan meetings as well as discussions with the doctor if requested by family.

This person could set up a booket with all the questions that need to be asked when selecting a nursing home. (See the attached list taken from the book You, Your Parent, and the Nursing Home by Nancy Fox plus a few additional questions).

Additional points of importance should be included in the booket as follows:

Families should be told that they have a right to exercise the three V's—visit as often as they want, Keep a vigilance over patient's care and vocalize when the care is bad OR good.

Families should be encouraged to inform prospective nursing home of patient's specific problem and get assurance that every effort will be made to solve the problem and, if at all possible insist on meeting and talking with doctor who will be caring for the loved one.

Families should be informed if not genuinely satisfied with first nursing home selected after a fair trail, move patient to another one if well being of patient is in jeopardy.

Families should be made aware that they do not have to use the nursing home doctors. They have a choice of selecting one to their liking.

(10). If I were going to go through the traumatic experience again of placing a loved one in a nursing home, since nursing was the principal department I had to deal with and was the department mostly related to my loved one's care I would have made it a point to have a more thorough interview with the Director of Nursing and the Nursing Supervisor to determine what their philosophy of care was for the geriatric patient and how much emphasis they placed on keeping the family unit involved and whether or not they believed in treating the whole person.

The fact that the home is clean and nicely decorated and that the staff is friendly is not of prime importance. These are just basics to good care. They are not enough when the total well being of a loved one is at stake. Total care of mind, body and spirit is a must.

Before selecting a nursing home families must know the questions to ask. In Question 8 I have attached a list of such questions but even in the nursing homes where nearly all of the questions can be given a positive answer, appropriate or good medical care is lacking.

I think family participation in planning patient's physical care and medical treatment as indicated in Patients' Bill of Rights is the key and this is where the concentrated effort should be made as well as concentration on compliance with the entire Patients' Bill of Rights. Families must be encouraged to exercise these rights. I feel there would be more family participation if family was not discouraged by Nursing Home Administration.

[Enclosure 2]

(1). How much time did you have to decide on a nursing home?

None. Patient was transferred from hospital to 1st available bed in nursing home.

(2). Who did you talk with to get information on nursing homes?

I talked with representatives of 3 nursing homes prior to my mother being admitted. None of the nursing homes had a bed available and there would be a lengthy wait. After mother became hospitalized, she was classified as nursing home placement and was transferred from hospital to River Walk Manor.

(3). What information did you want and didn't get?

None

(4). What information was most helpful in your decision?

N/A

(5). Did you get too much or too little information?

N/A

(6). Were you aware of the Ombudsman Program?

Not when my mother was first admitted to a nursing home. See attached.

(7). What information was your decision based on?

Visit to nursing home
Recommendation
Only bed available
Cost
Other (Please explain)

(8). If there was a service designed to meet your needs what would it look like?

An in-house patient/family representative that was not employed by the nursing facility.

(9). Are you satisfied with your decision?

N/A

What would help?

(10). Other

See attached.

[Attachment]

In November 1978, we realized mother was becoming increasingly disoriented. We had her evaluated by the Wicomico County Geriatric Evaluation Service and nursing home placement was recommended. I visited or called three nursing homes in the area and was not at all impressed with the responses I received. All the nursing homes advised there were no beds available and the waiting list was quite long.

Since my mother lived alone in a small apartment, approximately 45 miles from my residence, I worried constantly about her leaving the stove on, not eating properly, falling, wandering off, etc. It was not feasible for her to live with us as we were living in a 2 bedroom trailer and I worked shift work. I felt she would be more comfortable in familiar surroundings until such time we were able to place her in a nursing home. Meals were delivered to her daily and her sister-in-law and neighbors checked on her frequently.

In January 1979, one day when her daily meal was delivered, she failed to answer the door. Groaning could be heard coming from inside her apartment and mother's sister-in-law was contacted immediately. It was found that mother had fallen and was unable to get up. She was transported to the local hospital. After X-rays and other testing, it was found she had suffered no broken bones or dislocations. She remained in the hospital approximately 10 days until a bed became available in a nursing home. Therefore, I had no choice of this nursing home placement.

At this time I was a resident of Delaware, and I contacted Mr. Barnes of the Shangri La Nursing Home in Delmar. He advised me that as soon as a bed became available, we would be able to transfer mother to Shangri La. This was done approximately 3 months later. I was very satisfied with this placement. I was able to visit mother daily, take her out for rides, bring her home with me for meals and visits, etc. Several years later, Shangri La was sold or leased and then became Loving Care Nursing Home, with new owners. It was at this time my problems began. After several months of politely requesting the nursing home personnel not to place urine soaked clothing in mother's closet, I finally contacted the Wicomico County Geriatric Evaluation Service, who in turn referred me to the Ombudsman Program for Wicomico County.

I cannot describe in words how invaluable Mrs. Mooney of the Wicomico County Ombudsman Program has been with reference to the problems I have experienced in dealing with the nursing home. I have contacted Mrs. Mooney on many, many occasions and have always been given the most courteous, compassionate, and knowledgeable assistance. She has been my lifeline as to coping with my mother's nursing home care. Without going into detail of my numerous calls to the Ombudsman Program, I would like to mention one incident which was most beneficial financially to my family. Mrs. Mooney discovered an article in the Patient's Bill of Rights which saved me approximately $500 or possibly more by forgoing the necessary attorney fees and a hearing in court with regard to Power of Attorney.

Due to having dealt with nursing homes for the past six years with regards to my mother's care and treatment, I feel qualified to state that I think the Long-Term Care Ombudsman Program and the Geriatric Evaluation Service are two programs the State of Maryland has that I believe are the best possible for the elderly patients and their families.

KAY S. TAYLOR,
Delmar, DE.

LONG-TERM CARE OMBUDSMAN PROGRAM OF THE LOWER EASTERN SHORE

[Fiscal years]

	Yearly analysis			
	1980-81	1981-82	1982-83	1983-84
Total grievances	153	166	147	188
Total inquiries	28	20	37	22
Grand total	181	186	184	210
Grievance category:				
01 Nursing services	49	33	36	39
02 Dietary service	23	15	13	23
03 Physical environment	8	9	12	16
04 Financial	12	7	3	12
05 Medical service	5	5	4	5
06 Medication	1	6	5	2
07 Legal service	1	0	0	0
08 Protective service	0	1	0	0
09 Abuse	10	2	11	9
10 Administrative problems	4	38	40	29
11 General services	5	10	6	7
12 Discharge/transfer	15	20	5	15
13 Personal possessions	13	17	5	10
14 Not against facility	([1])	3	7	11
Complaints validated (percent)	49	49	50	57
Complaints undetermined (percent)	24	23	25	24
Complaints not valid (percent)	27	28	25	19
Information/inquiries				
15A Placement and transfer	5	2	8	2
15B Ques. specific nursing homes	7	2	1	4
15C Ques. resident rights; regulations; etc	1	6	18	7
15D Ques. LTCOP	2	2	4	2
15E Information and community resources	10	8	6	7

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[1] In January 1982 the complaint categories were made uniform throughout the State. This was not a category prior to January 1982. Fiscal year 1980-81: There are 7 grievances not accounted for. Prior to January 1982 they were under the category of resident's rights. There are 3 information and inquiries not accounted for. Prior to January 1982 they were under the category of referrals.

PREPARED STATEMENT OF VIVIAN OMAGBEMI, MONTGOMERY COUNTY LONG-TERM CARE OMBUDSMAN, MONTGOMERY COUNTY, MD

My name is Vivian Omagbemi, and I have been a Long-Term Care Ombudsman for two years and half. I direct a substate Ombudsman program in Montgomery County, Maryland. I work for Montgomery County Government Department of Family Resources Division of Elder Affairs. I have been in the long-term care field for four years. I am a Registered Nurse and have worked one year as a Health Facility Surveyor in the local Licensing Agency.

Montgomery County Ombudsman Program is responsible for twenty-six nursing homes and two domiciliary homes, a total population of 4,000 residents. The paid staff consists of one full-time Ombudsman, one part-time Assistant Ombudsman and one full-time administrative assistant. In the 1985 Fiscal Year, the Program received 340 complaints. It was able to validate 300 of the complaints and resolved 290 complaints.

The Ombudsman Program has been involved with abuse cases, illegal transfers and discharges, illegal guardianship petitions, nursing problems privacy issues, and negligence which have caused injury and death to residents. The knowledge of these problems have been brought to the attention of the Ombudsman Program by residents, families, friends, staff of nursing homes, staff of hospitals, volunteer advocates and outside agencies.

The most consistent means of obtaining knowledge of a problem has been through the constant exposure of the Ombudsman Program in the facility. Because of the lack of paid staff, the Montgomery County Ombudsman is extremely dependent on volunteers to provide that exposure. Our long-term care volunteer advocates are a special necessary component of our program. They are special because the expectations we place on them are awesome. They have to go through an intensive 24-hour training program. They learn the history of nursing homes, laws and regulations governing the nursing homes, patient's rights, problem solving, communication and resolution skills, aging process and how to develop resident/family councils. Then every month, they have a two-hour in-service where they receive peer and program support; and they also obtain additional information needed to perform their task.

We ask them to be advocates, fact finders, negotiators, educators, referral agents, and mediators. We ask them to give four-hour/week for one year of their lives. We asked them to build trusting relationship with residents so that the resident will begin to share real concerns and problems they are having. We asked them to build trusting relationship with nursing home staff so when problem do arise negotiations and change may occur easier.

This volunteer job is not prestigious. It is not fun. It bears a lot of frustration, anger, sadness and depression. But even with all that, resolutions do occur and positive changes have been made by the volunteer advocates. Their constant presence in the facility allows families and residents to understand their rights and to provide them with timely intervention. This was proven by a family member that testified on behalf of the Ombudsman Program during this hearing. She stated, if it wasn't for the constant presence of the volunteer advocate, she would not have known about the Ombudsman Program.

Presently, there are eight volunteers and each one is assigned to a nursing home facility. They served approximately 1,044 residents. Enclosed is their Job Description. The 18 facilities or 2,956 remaining residents, not covered by volunteer advocates, are visited by the paid staff when there is a complaint. As part of her educational role, the Ombudsman also visits the nursing home to give in-service to its staff.

In the last two years, there has been four recruitment drives and training sessions. 26 participants came to the training. 16 joined the Program. 13 stayed less than three months. Only three remained.

To have to depend on volunteers to implement an important and needed program seems unfair to the consumers. If the Administration on Aging really supported the Ombudsman Program, adequate funding would be given to hire and train enough staff to implement the program as it was done in the initial pilot project. The Ombudsman Program is needed. It has been successful, but in order for it to continue, we need the financial support and technical assistance support from the Administration on Aging.

NEW HAMPSHIRE STATE COUNCIL ON AGING,
OFFICE OF OMBUDSMAN,
Concord, NH, October 2, 1985.

Hon. MARIO BIAGGI,
Chairman, Select Committee on Aging,
Washington, DC.

DEAR REPRESENTATIVE BIAGGI: This is in response to your September 19th letter to this office requesting testimony on the status of the Long Term Care Ombudsman Program.

It is the opinion of this office that the Ombudsman Program would be more effective as an independent agency. This would give the program the greatest amount of independence and impartiality in dealing with Long Term Care Facilities and State Agencies. This independence would allow the Ombudsman to make suggestions and recommend legislation without interference from either the executive or a state agency. Legislation requiring Ombudsman Programs to be placed in independent agencies would ensure the independence and effectiveness of the programs.

The most pressing problems out of this office have involved abuse of the elderly and the lack of appropriate protective services for the elderly. This office is currently responsible for the investigation of abuse in Long Term Care Facilities. However, the corresponding state agency for adult abuse has refused to coordinate efforts or to refer Long Term Care Abuse cases to this office. Legislation would certainly be appropriate to designate the Ombudsman as the sole office to investigate abuse in Long Term Care Facilities. This is a logical extension to the role of the Ombudsman as the protector of the civil rights of nursing home residents.

The second issue is the lack of appropriate protective services for nursing home residents. There are a significant number of nursing home residents who are being exploited by their families who are in need of protective services and who are not receiving them. In addition, there are significant numbers of incompetent residents without families who have no guardian or other type of substitute decision-maker. This leaves these people virtually helpless and dependent on the nursing homes to provide their needs.

Thank you for the opportunity to submit this testimony. If I can be of further help to your committee, please feel free to contact me.

Sincerely,

JERILYN M. PELCH,
State LTC Ombudsman.

Enclosures.

Office of Ombudsman

Redesignation of provisions of subdivision. For discussion of redesignation of provisions of this subdivision, see revision note following the analysis for this chapter.

167-A: 21 Definitions. As used in this subdivision, the following terms shall have the following meanings unless the context clearly indicates otherwise.

I. An "act" of any facility or government agency shall be deemed to include any failure or refusal to act by such facility or government agency.

II. "Administrator" means any person who is charged with the general administration or supervision of a facility whether or not such person has an ownership interest and whether or not such person's functions and duties are shared with one or more other persons.

III. "Council" means the state council on aging.

IV. "Elderly" means any person 60 years of age or older who is a patient, resident or client of any facility.

V. "Facility" means any facility or institution, whether public or private, offering health or health related services for the institutionalized elderly, and which is subject to regulation, visitation, inspection, or supervision by any government agency. Facilities include, but are not limited to, nursing homes, skilled nursing homes, intermediate care facilities, extended care facilities, convalescent homes, rehabilitation centers, homes for

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the aged, special hospitals, veterans hospitals, chronic disease hospitals, psychiatric hospitals, mental hospitals, mental retardation centers or facilities, day care facilities for the elderly, medical day care centers and boarding homes, other homes for sheltered care, or any facility or institution housing 2 or more supplemental security income recipients. /L/

VI. "Government Agency" means any department, division, office, bureau, board, commission authority or any other agency or instrumentality created by any county or municipality or by the state, or to which the state is a party, which is responsible for the regulation, inspection, visitation or supervision of facilities or which provides services to patients, residents or clients of facilities.

VII. "Office" means the office of ombudsman established herein.

VIII. "Ombudsman" means the person who is the administrator and chief executive officer of the office of ombudsman.

IX. "Patient, resident or client" means any elderly person 60 years of age or older who is receiving treatment, care of housing in any facility in all its aspects including, but not limited to, admission, retention, confinement, commitment, period of residence, transfer, discharge and any instances directly related to such status.

X. "Director" means the director appointed pursuant to RSA 167-A:8.

Source. 1979, 395:2. 1983, 33:1, eff. June 11, 1983.

Amendments—1983. Paragraph V: Substituted "boarding homes, other homes for sheltered care, or any facility or institution housing 2 or more supplemental security income recipients" for "nursing homes or other homes for sheltered care" following "medical day care centers and" at the end of the paragraph.

Purpose. 1979, 395:1, eff. July 1, 1979, provided:

"I. The legislature hereby finds:

(a) that, in response to the varied health and health related problems experienced by the different age groups within the general population, numerous health care facilities have been constructed and placed in operation to provide specialized health and health-related services to such groups; and

(b) that, in providing such services to the elderly, it is essential to recognize that, while the members of this age group possess the same civil and human rights as the members of every other age group, such rights may be far more difficult for certain of the elderly to secure since such persons may be afflicted with physical or mental infirmities or both, deprived of the comfort and counsel of family or friends or both, and forced to exist with minimum economic resources, all of which may preclude them from defending and acting in their own interests; and

(c) that, to the degree that certain of the elderly may experience difficulty in securing their civil and human rights as patients, residents and clients of the health care facilities created to serve their specialized needs and problems, it is the obligation of the state to take appropriate action through the creation of a special framework by which those rights shall be protected.

"II. The legislature, therefore, declares that it is the public policy of this state to secure for the elderly patients, residents and clients of health care facilities serving their specialized needs and problems the same civil and human rights guaranteed to all citizens; and that, to this end there should be established within state government the office of ombudsman to receive, service, investigate and resolve complaints or problems concerning certain health care facilities serving the elderly which would adversely affect the health, safety, welfare and civil and human rights of elderly patients, residents and clients of such facilities."

167-A:22 Office Established. There is hereby established the office of ombudsman within the state council on aging. The office shall be responsible for receiving, servicing, investigating and resolving complaints or problems concerning certain health care facilities and for investigating

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the administrative acts and omissions of any government facility or agency as defined in RSA 167-A: 21, V and VI.

Source. 1979, 395: 2, eff. July 1, 1979.

167-A: 23 Ombudsman. The director, subject to the approval of the council, shall hire a person as the administrator and chief executive officer of the office who shall be called ombudsman and who shall be a person qualified by training and experience to perform the duties of the office. The ombudsman shall hire such other persons needed to perform the functions of this office. The ombudsman shall devote his entire time to the duties of his position and shall receive such salary as shall be provided in a classified position under regulations set forth in policy by the department of personnel.

Source. 1979, 395: 2, eff. July 1, 1979.

167-A: 24 Filling Vacancy. Any vacancy occurring in the position of ombudsman shall be filled as provided in RSA 167-A: 23; except however, that, whenever the ombudsman dies, resigns or becomes ineligible to serve for any reason or is removed from office for just cause, the director subject to the approval of the council may appoint an acting ombudsman who shall serve until the appointment and qualification of a permanent ombudsman but never longer than 6 months from the occurrence of the vacancy.

Source. 1979, 395: 2, eff. July 1, 1979.

167-A: 25 Powers and Duties.

I. The ombudsman, as administrator and executive officer of the office, shall, subject to the approval of the director and council:

(a) Adopt rules, pursuant to RSA 541-A, prescribing duties for the efficient conduct of the business, work and general administration of the office.

(b) Adopt rules, pursuant to RSA 541-A, relative to eliciting, receiving, investigating, responding to and resolving complaints or problems from any person or agency involving patients, residents or clients of facilities.

(c) Acting on complaint, investigate any act, practice, policy or procedure of any facility or government agency that does or may adversely affect the health, safety, welfare or civil or human rights of any patient, resident or client of a facility.

II. The files maintained by the ombudsman program shall be disclosed only with the written consent of the complainant, or a patient, resident or client of a facility, or his legal representative, or if such disclosure is required by court order. Nothing herein shall be construed to prohibit the disclosure of information gathered in any investigation to any interested party as may be necessary to resolve the complaint.

Source. 1979, 395: 2. 1983, 33: 2, eff. June 11, 1983.

Amendments—1983. Amended section generally.

167-A: 26 Access to Records, etc.

I. In an investigation, the representative of the office may:

(a) Make the necessary inquiries and obtain such information as he deems necessary;

(b) Enter during normal working hours and, after notifying the person in charge of his presence, inspect the premises of a facility or govern-

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ment agency and inspect there any books, files, medical records or other records that pertain to patients, residents or clients and are required by law to be maintained by the facility or government agency;

II. In an investigation, the representative of the office shall have the authority to apply to the superior court for an order authorizing entry when an administrator of a facility refuses such representative entry as provided in paragraph I(b).

Source. 1979, 395:2, eff. July 1, 1979.

167-A:27 Retaliation Prohibited; Penalty.

I. No discriminatory, disciplinary or retaliatory action shall be taken against any officer or employee of a facility or government agency by such facility or government agency nor against any patient, resident or client of a facility nor against any guardian or family member of any patient, resident or client nor against any volunteer for any communication by him with the office or for any information given or disclosed by him in good faith to aid the office in carrying out its duties and responsibilities.

II. Any person who knowingly or willfully violates the provisions of this section shall be guilty of a misdemeanor.

Source. 1979, 395:2, eff. July 1, 1979.

167-A:28 Cooperation Required. The office may request from any government agency, and said agency is hereby authorized and directed to provide, such cooperation and assistance, services and data as will enable the office properly to perform or exercise any of its functions, duties and powers under this subdivision.

Source. 1979, 395:2, eff. July 1, 1979.

167-A:29 Review; Report Required. The director and council shall review on a regular basis the development, implementation, administration and operation of the office provided for in this subdivision. To facilitate this review, the office shall submit such reports as called for by the director and council from time to time and shall submit an annual report no later than 60 days after the close of the fiscal year.

Source. 1979, 395:2, eff. July 1, 1979.

RULES AND REGULATIONS

OFFICE OF OMBUDSMAN

1-800-442-5640

STATE OF NEW HAMPSHIRE
COUNCIL ON AGING
14 DEPOT STREET
CONCORD 03301
EFFECTIVE: OCTOBER 4, 1983
271-2751

OCT 07 1985

Chapter/Part __Omb 100, 200, 300, 400 through 402

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NEW HAMPSHIRE CODE OF ADMINISTRATIVE RULES

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NEW HAMPSHIRE CODE OF ADMINISTRATIVE RULES

OFFICE OF OMBUDSMAN
State Council on Aging
14 Depot Street
Concord, New Hampshire 03301
Telephone: (603) 271-2751

CHAPTER Omb 100 ORGANIZATIONAL STATEMENTS

PART Omb 101 DEFINITIONS

Omb 101.01 Statutory Definitions Adopted. "Facility", "act", "administration", "elderly", "government agency", "patient, resident or client" shall have the same meaning as in RSA 167-A:21.

Source. #2499, eff 10-4-83

Omb 101.02 "Long-Term Care Ombudsman" means the person appointed under RSA 167-A:21 as the administrator and chief executive officer of the office of ombudsman.

Omb 101.03 "Authorized representative" means a person, hired or appointed by the long-term care ombudsman, who assists in carrying out the duties and responsibilities of the office of ombudsman.

Source. #2499, eff 10-4-83

Omb 101.04 "Complainant" means a resident of long-term care facilities or a person acting directly for or on behalf of a resident, including, but not limited to family members, friends, staff of nursing homes, citizens' organizations and associations, or governmental agencies.

Source. #2499, eff 10-4-83

Omb 101.05 "Complaint" means a written or verbal statement or alleged violation of a statute, regulation, or policy or other alleged wrongful acts or omissions by a facility or a government agency or by a person(s) which affects the health, safety, welfare, civil and human rights of an elderly person living in a facility.

Source. #2499, eff 10-4-83

Omb 101.06 "Referral" means sending or communicating a complaint to another agency which is separate from the long-term care ombudsman's Office.

Source. #2499, eff 10-4-83

Omb 101.07 "Recommendation" means a written statement, by the ombudsman's office, of actions to be taken by the parties involved after an investigation has been completed.

Source. #2499, eff 10-4-83

Omb 101.08 "Abuse" means intentional use of physical force, non accidental injury as the result of acts or omissions, mental anguish, or unreasonalbe confinement.

Source. #2499, eff 10-4-83

Omb 101.09 "Neglect" means a pattern of conduct rather than action or omission which results in deprivation of services that are necessary to maintain minimum mental and physical health.

Source. #2499, eff 10-4-83

Omb 101.10 "Exploitation" means the illegal or improper use of an incapacitated adult or his resources for another's profit or advantage.

Source. #2499, eff 10-4-83

Omb 101.11 "Normal working hours" means 24-hours, 7-days a week in a facility.

Source. #2499, eff 10-4-83

Omb 101.12 "Consumer" means any person who is or has been a resident or client or any person who is a responsible party for someone in a facility.

Source. #2499, eff 10-4-83

Omb 101.13 "Investigation" means the process whereby the Ombudsman verifies or does not verify the charges of the complaint. The investigatory process seeks to establish what happened, why it happened, and who or what was responsible.

Source. #2499, eff 10-4-83

Omb 101.14 "Access" to long-term care facilities and their residents means the Ombudsman has the right to:

(a) Enter any facility;

(b) Communicate privately and without restrictions with any resident who consents to the communication;

(c) Seek consent from a resident to communicate privately and without restriction with that resident;

(d) Inspect the clinical and other records of a resident and any records required by regulation to be kept by a facility; and

(e) Observe all common areas of the facility except the living area of any resident who protests the observation.

Source. #2499, eff 10-4-83

PART Omb 102 DESCRIPTION OF THE OFFICE

Omb 102.01 Purpose. The office of long-term care ombudsman was established to protect the civil and human rights of elderly people living in facilities. Furthermore, the office of ombudsman is to safeguard the health, safety and welfare of elderly people living in such facilities.

Source. #2499, eff 10-4-83

Omb 102.02 Sources of Authority. The office of ombudsman receives its authority from the Older Americans Act PL-89-73 and New Hampshire revised statutes annotated, chapters 167-A:21-29 and 151:28,

(a) The Older Americans Act PL 89-73 Title III, Sec. 307 (a):12-16 says that states will:

> (1) "establish and operate, either directly, or by contract or other arrangement with any public agency or other appropriate private non-private organization which is not responsible for licensing or certifying long-term care services in the state or which is not an association (or an affiliate of such an association) or long-term care facilities (including any other residential facility for older individuals), a long-term care ombudsman program which will:
>
> a. investigate and resolve complaints made by or on behalf of older individuals who are residents of long-term care facilities relating to administrative action which may adversely affect the health, safety, welfare and rights of such residents;
>
> b. monitor the development and implementation of federal, state and local laws, regulations, and policies with respect to long-term care facilities in that state;
>
> c. provide information as appropriate to public agencies regarding the problems of older individuals residing in long-term care facilities;
>
> d. provide for training volunteers and promote the development of citizen organizations to participate in the ombudsman program; and
>
> e. carry out such other activities as the commissioner deems appropriate.
>
> (2) Establish procedures for appropriate access by the ombudsman to long-term care facilities and patients' records, including procedures to protect the confidentiality of such records and ensure that the identity of any complainant or

resident will not be disclosed without the written consent of such complainant or resident, or upon court order.

(3) Establish a statewide uniform reporting system to collect and analyze data relating to complaints and conditions in long-term care facilities for the purpose of identifying and resolving significant problems, with provision for submission of such data to the agency of the state responsible for licensing or certifying long-term care facilities in the state and to the commissioner on a regular basis.

(4) Establish procedures to assure that any files maintained by the ombudsman program shall be disclosed only at the discretion of the ombudsman having authority over the disposition of such files, except that the identity of any complainant or resident of a long-term care facility shall not be disclosed by such ombudsman, unless:

a. such complainant or resdident, or his legal representative, consents in writing, to such disclosure; or

b. such disclosure is required by court order.

(b) The New Hampshire Revised Statutes Annotated, Chapter 167-A:21-29, authorizes the office of ombudsman to receive, service, investigate, and resolve complaints or problems concerning facilities and to investigate the administrative acts and omissions of any government facility or agency.

(c) The New Hampshire Revised Statutes Annotated, Chapter 151:28 authorizes the office of ombudsman to determine the eligibility of organizations requesting access to nursing homes.

(d) The New Hampshire department of health and welfare, division of public health, He-P 801.05 authorizes that the long-term care ombudsman program receives: "All complaints regarding (patients' rights) for persons 60-years of age or older contained in RSA 151:19-30 shall be referred to the office of ombudsman, established under RSA 167-A:22."

(1) The New Hampshire department of health and welfare, bureau of adult services, Item 671:5603.4 authorizes that "any report alleging neglect, abuse, or exploitation in a long-term care facility is referred by the adult services supervisor to the chief, bureau of adult services at state office via form 607, (protection report form).

(2) The chief, bureau of adult services reviews the referral and forwards the report to the office of ombudsman through the state council on aging.

Omb 102.03 Duties of the Office. The long-term care ombudsman's office shall:

(a) Elicit, receive, investigate, respond to and resolve complaints or problems according to established policies and procedures including violation of New Hampshire's patients' bill of rights.

(b) Establish procedures that shall maintain confidentiality of all official files.

(c) Make necessary inquiries and obtain information necessary to fully investigate complaints.

(d) Design and implement a statewide uniform complaint documentation system.

(e) Annually report to the state licensing and certifying agency, the governor, the commissioner of health and welfare, and the public on the operation of the long-term care ombudsman program status of complaints, resolutions, and conditions in long-term care facilities in New Hampshire.

(f) Monitor the development and implementation of federal, state and local laws, regulations and policies that relate to long-term care facilities in the state.

(g) Upon request and as necessary and appropriate information to public agencies about the problems and concerns of older persons in long-term care facilities, recommend changes in the long-term care system which will benefit institutional residents as a class.

(h) Publicize the long-term care ombudsman program and provide information and education about long-term care issues in the state.

(i) Receive and review applications from community organizations for access to nursing homes.

(j) Document and investigate all reports of institutional abuse.

(k) Develop and implement sub-state programs and provide training on an on-going basis for staff and volunteers.

Source. #2499, eff 10-4-83

Omb 102.04 Authorized Representatives. The state long-term care ombudsman may delegate the powers and duties of the ombudsman's office for eliciting, receiving, investigating, responding to and resolving complaints or problems to authorized representatives of the office. Any individual to whom these powers and duties are delegated shall:

(a) Successfully complete a training program designed and offered by the state long-term care ombudsman;

(b) be supervised and provided on-going training and technical assistance by the state long-term care ombudsman; and

(c) abide by all the rules and regulations established by the office of ombudsman.

Source. #2499, eff 10-4-83

Omb 102.05 Reporting and Review.

(a) Reporting to state council on aging (SCOA)

(1) The SCOA shall appoint a member of its board to act as liaison between SCOA Board and the Office of Ombudsman.

(2) The SCOA shall appoint a member of its board to be a member of the ombudsman's long-term care advisory committee.

(3) The ombudsman shall review the program with the director of SCOA as needed and/or requested.

(4) The office of ombudsman shall submit copies of its annual report to the board liaison and the director of SCOA.

(5) The ombudsman shall present the annual report, in person, to the SCOA board and the governor's advisory committee. The board or committee may request other meetings.

(b) Reporting to the legislature, the office of the governor and the public.

(1) The ombudsman shall submit an annual report to the governor's office and the legislature.

(2) The ombudsman shall appear as required at any hearings on legislative issues that affect residents in long-term care faciliites and/or changes in legislation that affect facilities and agencies that provide service to residents of long-term care facilities.

(3) The ombudsman's annual report shall be available upon request by anyone and a press release shall be issued with such notice.

PART Omb 103 OFFICE OF LONG TERM CARE OMBUDSMAN - ADVISORY COMMITTEE

Omb 103.01 Membership. With recommendations from the SCOA board and the governor's advisory committee, members shall be invited to serve by the long term ombudsman.

(a) Memberhsip shall not exceed 24 people at any one time.

(b) Members shall include:

(1) 6 consumers with at least 2 being current nursing home residents;

(2) 5 representatives of providers of long-term care services;

(3) 5 representatives of government agencies;

(4) 1 representative from the state council on aging board, and 1 from the governor's advisory committee; and

(5) 6 other members selected from other concerned community organizations and professional organizations.

(c) Each member shall serve a minimum of 12 months with no member serving more than 36 consecutive months.

(d) The committee shall meet at least four times per year.

(e) Staff to the committee shall include the state long-term care ombudsman and the elderly legal services development director. Other staff may be appointed by the state long-term care ombudsman.

Source. #2499, eff 10-4-83

Omb 103.02 Activities of Advisory Committee. Because of their special expertise and perspective the advisory committee may:

(a) study and make recommendations about specific long-term care issues;

(b) establish committees to assist the state long-term care ombudsman program in carrying out its responsibilities;

(c) act as advocates for issues that involve residents of long-term care facilities; and

(d) assist in establishment of program priorities.

Source. #2499, eff 10-4-83

CHAPTER Omb 200 RULES OF PRACTICE AND PROCEDURE

Statutory Authority: RSA 167-A:25

PART Omb 201 COMPLAINT PROCEDURES

Omb 201.01 Eliciting and Receiving Complaints.

(a) A complaint may be made to the office of state ombudsman by:

(1) telephone;

(2) mail;

(3) personal contact; and

(4) in-person contact during a facility visit.

(b) The person receiving the complaint shall follow the following procedures:

(1) All complaints, however received, shall be entered in the central complaint log OMB #11 and shall include the following information:

a. date of complaint and case ID number;

b. name of complainant and name of facility or agency;

c. nature of complaint; and

d. action taken, verification, resolution, and date closed.

(2) An intake form, OMB #3, shall be completed on all complaints. If it is a new complaint by a previous complainant, a new intake form shall be completed and placed in the case record. The following information shall be included:

a. name, address, and telephone number of complainant and facility or agency;

b. subject of complaint;

c. name, address and telephone number of others who could substantiate complaint;

d. permission to use name in the investigation;

e. signature of complainant when appropriate.

(3) For each new case, a case record is started. Cases shall be filed under the name of the facility or agency and given a case identification number.

(4) The complainant shall be asked to sign a complaint form and a release of patient records, when applicable.

If the complainant refuses to sign a complaint, such complaint shall be treated as an anonymous complaint.

(c) All complaints, however received, shall be investigated or referred to the appropriate agency as promptly as possible. When a complaint alleges endangerment of life/safety, the complaint shall be investigated or referred within 72 hours of receipt.

Source. #2499, eff 10-4-83

Omb 201.02 Anonymous Compalints.

(a) All complaints shall be accepted, including both anonymous complaints and complaints from persons who do not wish to have their identities disclosed.

(b) Anonymous complainants shall be advised about the possible limitations to investigation and to the resolution of the complaint due to the anonymous nature. The ombudsman may attempt to convince the complainant to allow his/her identity to be revealed when:

(1) it is impossible to investigate the complaint without revealing the complainant's name; or

(2) the complainant's remaining anonymous would endanger the life or safety of a person.

Source. #2499, eff 10-4-83

Omb 201.03 Referral of Complaints.

(a) It shall be appropriate in some circumstances to refer complaints to other public or private agencies without investigation by the ombudsman.

(b) Form #9, interagency referral shall be completed in duplicate, one kept by the ombudsman's office and one sent to the agency. A written report from the agency may be requested on a referral. Information required shall include:

(1) name of facility or agency;

(2) problem description; and

(3) action taken prior to referral (if any).

(c) The office of ombudsman shall obtain the complainant's or resident's consent to refer the complaint and shall advise of agency referred to except when the complaint involves a criminal offense such as abuse or fraud. In such cases, the complainant shall be advised that their names shall be given to the proper enforcement agency upon verification of the complaint.

(d) The office of ombudsman shall insure that the complainant is advised of the status of the investigation and receives a report of the outcome from the referral agency.

(e) The ombudsman may critique, correct, or contest findings as appropriate, according to the complainant's reaction to investigative findings, on his/her behalf.

Source. #2499, eff 10-4-83

PART Omb 202 INVESTIGATION OF COMPLAINT

Omb 202.01 Complaint Analysis. The long term care ombudsman and/or authorized representative when investigating a complaint shall include, but not be limited to:

(a) A clear statement of the problem shall be obtained from the complainant. If the complaint is not received directly from the complainant, contact shall be made with the person(s) who has the complaint.

(b) The ombudsman shall contact pertinent parties to the complaint either by phone, mail, or in person to obtain details of the complaint.

(c) The ombudsman shall review all of the information and identify the relevant issues and if applicable the state and federal law which has or is being violated.

(d) The ombudsman shall develop and implement a strategy to resolve the complaint including referral to another agency.

Source. #2499, eff 10-4-83

Omb 202.02 On-Site Facility Visits.

(a) The ombudsman may make an on-site visit in order to observe the facility setting relevant to the complaint. These visits shall be unannounced and shall be at the approximate time involved in the complaint.

(b) The ombudsman may interview, as appropriate, residents, staff, administration, owner, or any other person(s) who may be able to provide information regarding the complaint.

(c) The ombudsman may request a review of any pertinent facility records or data that could provide information about the complaint.

(d) A conference shall be held with the administrator or his/her designee and other administrative staff as indicated. The ombudsman may:

(1) advise the facility of findings;

(2) make recommendations, if needed; and

(3) suggest follow-up actions by facility and/or ombudsman to resolve the complaint.

Source. #2499, eff 10-4-83

Omb 202.03 Government Agencies. When a complaint is received about an administrative act or omission of a government agency, the ombudsman shall follow the procedures in section Omb 202.01 and 202.02 excepting that the visit(s) and interview(s) shall include the agency's personnel, and if necessary review of the agency's records.

Source. #2499, eff 10-4-83

Omb 202.04 Report of Findings

(a) The ombudsman shall have regular, periodic communication with the complainant or resident and facility or agency related to progress of the investigation of the complaint, or for further information.

(b) A final report of findings shall be given to the complainant, resident, and the facility or agency.

(c) Any investigation that reveals a potential violation of state or federal law shall be immediately referred to the appropriate state or federal agency including but not limited to the attorney general, professional licensing board, bureau of health facilities, division of welfare, adult services, consumer affairs, or law enforcement branch.

Source. #2499, eff 10-4-83

PART Omb 203 VERIFICATION OF COMPLAINTS

Omb 203.01 Criteria for Validation

(a) Verified by Strong Standard. A complaint shall be considered verified if one or more of the following criteria are met;

(1) Observed by ombudsman;

(2) Substantiated through interviews, records, inspections and/or observations;

(3) Reported in licensing or survey reports; or

(4) Acknowledged by facility.

(b) Partially Verified. A complaint shall be considered partially verified, if a portion of the complaint is verified, and/or the complaint is supported by evidence which is contradictory but tends toward validity.

(c) Unable to Determine Validity. A complaint shall be classified as unable to determine validity, when there is not enough information to classify the complaint as either valid or invalid.

(d) Invalid. A complaint shall be considered invalid, if the complaint is shown to be invalid by the standards created in Omb 203.01 (a) or (b).

(e) Other. Complaints shall be classified in this category, when the nature of the complaint is such that it is not applicable to validation criteria.

Source. #2499, eff 10-4-83

Omb 203.02 Complaints Not Verified.

(a) After an investigation, complaints may be found to have no merit. The ombudsman shall explain the findings fully to the complainant, and if necessary, discuss alternate remedies.

(b) The case shall then be considered closed, and that complaint is counted as not verified, and not counted in "complaints" against facility.

(c) The facility or agency shall be notified, in writing, of the ombudsman's findings.

Source. #2499, eff 10-4-83

PART Omb 204 RESOLUTION OF COMPLAINTS

Omb 204.01 Purpose. Complaint resolution is the translation of the investigation results into beneficial action on behalf of the complainant and resident. This process shall insure that, to the degree possible, complainant/resident and/or ombudsman expectations and objectives relative to the complaint are achieved.

Source. #2499, eff 10-4-83

Omb 204.02 Actions by Ombudsman. In resolving a complaint the ombudsman may utilize one or more of the following strategies:

(a) negotiation - mediation;

(b) education/technical assistance;

(c) referral to another agency(s);

(d) regulatory or statutory change;

(e) legal action;

(f) involvement of community and professional organizations; or

(g) utilization of media.

Source. #2499, eff 10-4-83

Omb 204.03 Follow-up of Resolution.

(a) Follow-up visit(s), in 30-90 days, may be made to any facility or agency that has had a validated complaint.

(b) During the re-visit the ombudsman shall determine if the resolution is still in effect, and if not, why not.

(c) If the resolution is not in effect, the ombudsman shall determine if it may be necessary to reopen the case.

Source. #2499, eff 10-4-83

PART Omb 205 RETALIATION PROHITITED

Omb 205.01 Reporting. Any action of retaliation or attempt at intimidation of a resident, employee, volunteer or family member shall be reported immediately to the state office of ombudsman.

Source. #2499, eff 10-4-83

Omb 205.02 Review of Allegations. The state long term care ombudsman shall meet within 72 hours with the facility administrator or owner. The complaining party(s) may be included in the meeting(s).

Source. #2499, eff 10-4-83

Omb 205.03 Remedies. A final resolution shall be a written agreement satisfactory to the state long term care ombudsman. If resolution cannot be achieved the state long term care ombudsman shall refer the case to the attorney general's office for possible action under RSA 167-A:27, II.

Source. #2499, eff 10-4-83

PART Omb 206 RESERVED

CHAPTER Omb 300 ACCESS

PART Omb 301 OMBUDSMAN'S OFFICE

Statutory Authority: RSA 167-A:26 and RSA 167-A:28

Omb 301.01 Access to Facilities and Agencies.

(a) The ombudsman or authorized representative shall enter the facilities and agencies during the normal working hours except in an emergency situation where there is cause to believe that there is danger to life and/or safety.

(b) If access is refused to the ombudsman's office, the state ombudsman shall immediately notify the attorney general's office who shall take legal action as it deems appropriate which could include but is not limited to a petition to superior court.

(c) The ombudsman or authorized representative shall normally report their presence in the facility to the designated person in charge and upon request by any staff, shall produce identification which establishes their affiliation with the long term care ombudsman's office, except in an emergency situation where there is cause to believe that there is danger to life and/or safety.

Source. #2499, eff 10-4-83

Omb 301.02 Access to Residents.

(a) The ombudsman or authorized representative shall have the right to present him/herself personally to the residents and to introduce him/herself, to explain the program and to provide information.

(b) The ombudsman or authorized representative shall receive permission before entering a resident's room. If the resident, due to a physical and/or mental condition, is unable to give such permission then the ombudsman may go into the resident's room.

(c) If the resident's room does not permit private consultation to occur between the ombudsman or authorized representative and resident, or if such consultation infringes upon the rights of roommates, then the ombudsman shall request an appropriate private place for such meeting.

(d) The resident(s) and ombudsman or authorized representative may also meet in any common area of the facility unless their presence there would infringe upon the privacy or rights of other residents.

(e) Facility staff may refuse or terminate an ombudsman visit with a resident only when such a visit is a direct threat to the health and safety of the resident and that information is documented by his/her physician in that resident's medical records.

(f) An exception to the above Omb 301.02(e) rule, occurs when the resident, willfully and knowingly with full information related to his medical condition, waives medical advice and chooses to meet the ombudsman in spite of the risk. In such cases, the facility may request that the resident sign an appropriate written statement in which he/she takes responsibility for his/her actions.

Source. #2499, eff 10-4-83

Omb 301.03 Access to Resident Records. These procedures accommodate the needs of the ombudsman program for access to information and the resident's right of privacy for their records.

(a) Access to medical or personal records shall be sought only where required to fully investigate:

(1) a specific complaint made by or on behalf of a resident or residents; or

(2) information about the conditions of the long-term care facility generally.

(b) The inspection of records shall be accomplished in conformance with RSA 167-A:26 in as private an area of the facility as possible.

(c) In cases involving a specific resident, the resident or his/her legal representative may be asked to sign a release of information form Omb #2. A copy of this signed release may be given to the facility for their records. Failure to obtain a signed release shall not prohibit the ombudsman from access to the resident's records.

(d) In cases involving the conditions of the long-term care facility generally, the state long-term care ombudsman may review patient records at random in order to determine the validity of the complaint. Records copied shall not have any identifying mark or note.

Source. #2499, eff 10-4-83

Omb 301.04 Disclosure of Resident's Records Information.

(a) The ombudsman's office shall not discuss or disclose information in the records or disclose a resident's identity outside of the ombudsman program of which they are a part, unless:

(1) the resident or legal representative has consented to such disclosure, and specifies to whom the information may be disclosed; or

(2) a court orders the disclosure.

(b) The ombudsman's office may request copies of the resident's records or parts thereof. The ombudsman's office shall reimburse the facility for copies.

Source. #2499, eff 10-4-83

Omb 301.05 Other Documents and Records of Facility and Agencies.

(a) The ombudsman shall have access to any books, files, or records that pertain to residents or clients and are required by law to be maintained by the facility or government agency.

(b) The ombudsman shall follow the procedures in Omb 301.03 and Omb 301.04.

Source. #2499, eff 10-4-83

PART Omb 302 APPROVED ORGANIZATIONS

Statutory Authority: RSA 151:28, RSA 167A:25

Omb 302.01 Definitions.

(a) "Bona Fide Community Organization" means a public agency or any other non-profit agency which provides health or social services to the elderly, or any church group, association of older persons or fraternal service club, if the purpose of such agency, program or organization includes rendering assistance to residents without charge, but only if there is neither a commercial purpose nor affect to such assistance.

(b) "Approved Organization" means either:

(1) a bona fide community organization which the ombudsman has determined to meet the criteria established under Omb 302.04(b); or

(2) a legal aid program.

(c) "Legal Aid Program" means a non-profit organization providing free legal services and/or advocacy assistance.

(d) "Access" to approved organizations means the right to:

(1) enter any long term care facility;

(2) communicate privately and without restriction with any resident who consents to the communication;

(3) seek consent from a resident to communicate privately and without restriction with that resident; and

(4) observe all common areas of the facility except the living area of any resident who protests the observation.

Source. #2499, eff 10-4-83

Omb 302.02 Application Procedures. Each organization seeking authorization for access under RSA 151:28 to long-term care facilities and their residents shall make written application to the ombudsman office and shall supply the following information:

(a) Name, address, and telephone number;

(b) Signature of the director, chairperson, or the authorized representative of the organization;

(c) Name and telephone number of the contact person;

(d) Statement as to whether the organization is seeking approval as:

(1) a bona fide community organization; or

(2) a legal aid program.

(e) A copy of the grant, charter, statute, certificate of incorporation, by-laws or other documentation, sufficient to prove the establishment and purpose of the organization;

(f) References from 2 or more agencies or organizations;

(g) Past and present activities and accomplishments of the organization; and

(h) Purpose in seeking authorization for access to long-term care facilities.

Source. #2499, eff 10-4-83

Omb 302.03 Review of Application. The office of ombudsman shall evaluate applications based upon the following criteria:

(a) Applicants shall submit all required application materials at one time to the office of ombudsman;

(b) An application shall be deemed to be received on the first day that all of the required application materials are delivered to the ombudsman office during their normal working hours (Monday-Friday 8:00 a.m. through 4:00 p.m.);

(c) A decision by the ombudsman office to approve or disapprove an application shall be made in writing within 30-days after receipt as required by RSA 151:28;

(d) If disapproved, the office of ombudsman shall indicate in the written notice the reason for disapproval, which may include:

(1) incomplete application;

(2) insufficient information;

(3) not a legal aid program; or

(4) not qualifying as a bona fide community organization.

Source. #2499, eff 10-4-83

Omb 302.04 Approval Criteria.

(a) Legal aid programs. The ombudsman shall approve an application from an organization seeking authorization for access as a legal aid program if the completed application documents the organization as a legal aid program.

(b) Bona fide community organization (BFCO). The ombudsman shall review the total application of an applicant seeking designation as a BFCO, including contact with references and investigation into past and present activities of the organization. In evaluating the organization, the ombudsman shall assess:

(1) Whether or not the organization is a public or non-profit agency, church group, association for older persons, fraternal service club, or similar type organization, which provides health or social services to the elderly without remuneration;

(2) Whether or not there is a commercial purpose or affect to the assistance;

(3) Whether or not more than half of their normal activities include one or more of the services listed below:

a. Visiting, talking with, and making personal, social, and legal services available to people;

b. Informing persons of their legal rights, entitlements and obligations by:

1. distributing educational materials; or

2. group and individual discussions;

c. Providing assistance to people in asserting their legal rights; or

d. Any other ways of helping people to achieve the full enjoyment of their rights; and

(4) Whether or not, based upon all the above considerations, the organization is more likely than not to use the access to improve the quality of life of the residents in long-term care facilities.

Source. #2499, eff 10-4-83

Omb 302.05 Obligations of Approved Organizations. All organizations approved for access to long-term care facilities shall:

(a) Furnish the office of ombudsman with a list of those individuals who will be using the access;

(b) Promptly notify the ombudsman of revisions to the list described in (a);

(c) Provide those individuals who will use the access with written identifications of their organizational affiliation;

(d) Terminate that documentation when the individual ceases to be a member of the organization or no longer will have access;

(e) Seek access only during regular visiting hours of the long-term care facilities;

(f) Show, upon request of a long-term care facilities representative the written identification;

(g) Identify him/her self to the resident and receive the resident's authority before entering a resident's personal living space;

(h) Respect the resident's right to terminate a visit;

(i) Keep confidential all communication with a resident; and

(j) Comply with the long term care residents bill of rights, RSA 151:21.

Source. #2499, eff 10-4-83

Omb 302.06 Long-Term Care Facilities' Obligations.

(a) A long-term care facility shall allow access during regular visiting hours to representative of approved organizations having proper identification.

(b) A long-term care facility shall not limit, restrict or otherwise discourage access by approved organizations.

(c) A long-term care facility shall not retaliate against a resident for communicating with a representative of an accessed organization.

(d) Retaliation shall include coincidental worsening of quality of care (including less staff time, inattention and long delays in calls for assistance, discrimination in feeding (cold food, poorer quality, delayed meals), verbal and physical threats, harassment, undocumented revisions in type, dosage, frequency of administration of medication, restrictions in permitted activities, (library privileges, therapy, social hours, etc.).

(e) A long-term care facility shall respect the confidentiality of communications between residents and representatives of accessed organizations.

Source. #2499, eff 10-4-83

Omb 302.07 Complaints by Long-Term Care Facilities. An administrator of a long-term care facility may file a complaint with the ombudsman if behavior of a representative of an accessed organization or policies of an accessed organization are threatening the health, safety or welfare of residents.

Source. #2499, eff 10-4-83

Omb 302.08 Complaints by Accessed Organizations. An accessed organization may file a complaint with the ombudsman if the organization:

(a) Is denied access to the facility or a resident;

(b) Is hindered in fulfilling purposes of access because of the facility's failure to honor confidential and private meetings, or to restrict group informational presentations;

(c) Suspects retaliation by the long-term care facility against residents; or

(d) Has any other basis to suspect the facility is undermining the purposes of access.

Source. #2499, eff 10-4-83

Omb 302.09 Receipt of Access Complaints. A long-term care facility or an accessed organization may file a complaint with the ombudsman. A complaint shall be submitted in writing and shall include:

(a) The name of the complainant;

(b) The facility or organization against whom the complaint is lodged;

(c) Description of specific complaint(s) including date(s) and time(s);

(d) Names of residents or individuals affected; and

(e) Any other information requested by the ombudsman.

Source. #2499, eff 10-4-83

Omb 302.10 Complaint Resolution. The ombudsman shall:

(a) Notify the organization or facility of the complaint and accept a reply from the organization or facility;

(b) Investigate the complaint according to usual complaint investigation procedures;

(c) Make written findings as to whether the complaint is validated or not;

(d) Meet when appropriate with the long-term care facility administrator and representative of the accessed organization to review findings and negotiate a resolution which may include removal/suspension of the individual from access to the long-term care facility, and revision of long-term care facility organization policies over accessed activities; and

(e) Notify, in writing, the long-term care facility and the accessed organization of the final resolution.

Source. #2499, eff 10-4-83

Omb 302.11 Termination of Access. The office of ombudsman shall notify in writing the accessed organization of its decision. In determining whether or not to terminate access of an individual or organization, the ombudsman shall consider:

(a) The number and type of prior validated complaints;

(b) Whether or not the complaint is against an individual or policy of the organization; and

(c) Severity of harm to residents' health and welfare.

Source. #2499, eff 10-4-83

Omb 302.12 Appeals. A facility or accessed organization may appeal a decision by the office of ombudsman under RSA 541.

Source. #2499, eff 10-4-83

CHAPTER Omb 400 RECORDS - Statutory Authority: RSA 167-A:25

PART Omb 401 CONFIDENTIALITY OF RECORDS

Omb 401.01 Ombudsman Files.

(a) The central complaint log and all case records (files) shall be secured in a locked file cabinet in the office of ombudsman. Only the state ombudsman or an authorized representative shall have access to these files.

(b) The records to be kept confidential include, but are not limited to:

(1) notes of the inverview with, or affidavits by, complainants;

(2) all copies of residents' medical records or diagnoses;

(3) all state long-term care ombudsman program memorandum which are developed in the process of evaluating and resolving residents' complaints;

(4) all photographs, videotapes, tape recordings of complainants/individuals;

(5) information containing unverified complaints about facilities, facilities' owners, administrators, staff, or other professionals involved in the long-term care system; and

(6) investigative materials and other information which is drafted and organized in the process of monitoring the development and implementation of laws, regulations, and policies affecting the long term care ombudsman.

Source. #2499, eff 10-4-83

Omb 401.02 Disclosure of Confidential Records. The state long-term care ombudsman shall be the sole custodian of the office records. Requests for disclosure of information shall only be granted when:

(a) A court, pursuant to RSA 167-A:25 IV, (a)(b), orders the disclosure; or

(b) The resident and/or complainant has consented, in writing, to release his/her identity for a time certain, specific, or general purpose, and has indicated in writing to whom such disclosure may be made:

(1) The client and/or complainant shall be required to sign Omb form #2 which shall include:

a. what information is to be released;

b. to whom and for what purpose information is to be released;

c. what the possible consequences of such release and information could be.

(2) Copies of Omb form #2 shall be given as required to:

a. The client and/or complainant;

b. The referral agency; or

c. The long-term care facility or government agency.

Source. #2499, eff 10-4-83

Omb 401.03 Referrals to Other Agencies.

(a) Records from the ombudsman's files pertaining to violations of licensure, certification, life safety, sanitation, fire, and/or zoning codes and ordinances shall be released to the bureau of health facilities administration, office of medicaid fraud and abuse, local or state fire and health departments, and other agencies with regulatory authority over these areas. Any release of this nature shall not include identification of the complainant or resident in the long-term care facility involved in the complaint without a signed release.

(b) Violations of a civil or criminal nature shall be referred to the attorney general's office pursuant to Omb 202.03 and 202.04.

Source. #2499, eff 10-4-83

Omb 401.04 Abuse Reporting.

(a) Institutional. Validated cases of institutional abuse shall be reported to the state office of adult services pursuant to N.H. division of health and welfare, item 671:5603.4, and to the bureau of health facilities administration pursuant to RSA 151:27 and RSA 151:29.

(b) Non-institutional. Complaints received by the office of ombudsman involving alleged non-institutional adult abuse shall be referred to the appropriate state district office of welfare.

Source. #2499, eff 10-4-83

Omb 401.05 Reports of Findings and Recommendations. The ombudsman's report to facilities and agencies of findings and recommendations shall protect the identity of the complainant(s) and/or the resident unless the complainant and client give a signed release of information.

Source. #2499, eff 10-4-83

Omb 401.06 Court Orders. Pursuant to a court order, disclosure of the ombudsman's files will be made, RSA 167-A:25. This shall include under RSA 167-A:25 IV, (b), an order by the court to testify in any judicial proceeding (including and/or criminal) regarding information which is considered confidential as defined in RSA 167-A:25 IV.

Source. #2499, eff 10-4-83

PART Omb 402 RESERVED

Source. #2499, eff 10-4-83

PREPARED STATEMENT OF DORIS R. STOUT, KANSAS CITY, MO

I recommend that Long Term Care Ombudsman offices be separate, independent agencies from state units on aging. Directors of state units on aging have different responsibilities and loyalties than those of the LTC Ombudsmen. The LTC Ombudsmen's first consideration must be the residents' welfare.

Conducting investigations in the fairest, most impartial manner possible, so that factual information can be presented to bring about effective change is paramount to the residents' interests. In Kansas by conducting investigations in this way we have won the respect and cooperation of consumers, the industry and other state agencies.

In one instance, however, during an investigation involving eleven residents I was not permitted to leave my office for several months to complete the investigation. I did as much investigation as possible by phone and in writing but could not do an appropriate investigation without further on-site review of records and interviewing of witnesses. An FBI agent called and requested that I come to his office to discuss the case. There were many impediments to my visit to the FBI office by a senior staff member of the state unit on aging. Only after I stated that I did not want to impair or even give the appearance of impairing a federal investigation was permission granted. The FBI is currently investigating an issue brought to my attention.

In Kansas the LTC Ombudsman has a mandated state statutory responsibility to prepare an Annual Report for the Legislature, the Governor and the Secretary on Aging. The law states also that the LTC Ombudsman work under the supervision of the Secretary on Aging. The LTC Ombudsman thus must work with the Secretary on Aging to prepare a report. The Annual Report to be an effective tool for the Legislature needs to be released in January when it convenes. The 1982 printed Annual Report was confiscated by the Secretary and released after the Legislature adjourned. The 1983 Annual Report was released again after the legislature adjourned. The 1984 Annual Report is yet to be printed although I prepared the report in a timely manner. On September 30 it will be time to draft the Annual Report for 1985.

During my absence the files were reviewed by the Special Assistant, who has had no training in investigation or more importantly in the confidentiality of records.

These are but a few of the incidents that have occurred that demonstrate the problems of an Ombudsman housed in a bureaucratic setting. I think there is a dichotomy in the law. When there are mandated responsibilities there ought to be congruent authority for carrying them out.

This year federal grants directly to the LTC Ombudsman will end. Administration monies will go directly to the state units on aging thus the federal government will not monitor the LTC Ombudsman Program in specific ways as in the past. This could dilute the program so that it is little more than a paper shuffling exercise.

I have been a practicing Ombudsman for twelve years; eight years in a general jurisdiction office and four years as Kansas Long Term Care Ombudsman. I have studied other Ombudsman offices here and abroad. It has been my experience that those offices that operate best to meet people's needs are those that are a separate agency unto themselves, usually with the Ombudsman chosen by a select committee of the legislature for a term of office.

I hope this information is helpful as you deliberate. Please let me know if you need further information or if I can assist you.

CITIZENS FOR BETTER CARE,
Lansing, MI, October 3, 1985.

Re: Status of the Long-Term Care Ombudsman Program under the Older Americans (OAA).

MARIO BIAGGI,
Chairman, Subcommittee on Human Services, Select Committee on Aging, Washington, DC.

DEAR CHAIRMAN BIAGGI, I am quite pleased to respond to your letter of September 19, 1985, and provide the Subcommittee with my experience and problems as Michigan's Long-Term Care Ombudsman. In the two years I have held the position, the joys and frustrations of State Ombudsman have been many.

Although 1985 is the tenth anniversary of amendments to the federal OAA mandating the creation of Long-Term Care Ombudsman Programs (LTCOP) in each state, the Michigan program is celebrating its thirteenth birthday this year. Michigan was one of the seven demonstration projects established during the Nixon Administration. Citizens for Better Care (CBC) has been the grantee agency for the Michigan LTCOP every year since 1972.

CBC is a non-profit, consumer organization headquartered in Detroit, Michigan. It began from a June 10, 1969, resolution from the Common Council of the City of Detroit requesting that the City's "Health Department to take leadership to encourage an association of nursing home and home for the aged users, their relatives, and other elements of the public interest, in order to help maintain high quality care where it now exists and to improve it where it doesn't." It has grown to a statewide educational and advocacy organization with over 700 members, five offices, 14 paid staff, and 100 volunteers.

Most of CBC's paid staff members are local or State Ombudsmen just as most of the vounteers serve as advocates in individual nursing homes across the state. The Michigan LTCOP is one of three major projects in CBC's work.

In the time I have been Ombudsman, the major elements of the Michigan LTCOP have been:

(1) Development of additional local Ombudsman projects; only five (5) of the state's fourteen (14) Area Agencies on Aging have local Ombudsman programs;

(2) Increased coordination with the Michigan Department of Public Health (MDPH), the state licensing agency for the state's nursing homes and homes for the aged, to insure a high quality of life and care within facilities under MDPH's authority;

(3) Receipt and investigation of complaints concerning the state's long-term care facilities, particularly for those in an area without a local Ombudsman's project;

(4) Support and technical assistance to the existing local Ombudsman programs;

(5) Monitoring and evaluation existing and proposed federal, state, and local laws, regulations, and policies affecting LTC residents and facilities; and

(6) Providing educational materials and presentations on LTC issues to interested persons and agencies.

These tasks are jointly developed by CBC and the Michigan Commission and Office on Services to the Aging (OSA), the state unit on aging. While the Michigan LTCOP is probably one of the "most independent" of all state LTCOPs in the country, it has received and looks forward to a strong relationship of support, coordination, and collaboration with the OSA and many OAA providers on LTC issues and concerns.

INDEPENDENCE FOR THE LTCOP

In the context of this background, I have several thoughts on your specific questions concerning the independence of the LTCOPs.

State Ombudsman, both within and outside state units on aging, complain about the lack of independence. A similarly diverse group do not have problems of independence or the ability to perform their OAA mandated tasks.

Some Ombudsmen feel "buried in state government" without access to decisionmakers for action or guidance on LTC issues and problems.

Some Ombudsmen, myself included, are frustrated by a philosophy within or interpretation of the OAA by many segments of the elderly services community that the focus of OAA resources should be those elders living in housing other than LTC facilities. The talk of "community-based services" rather than "long-term care services" perpetuates the gross myth that nursing homes and board and care facilities are not part of the community or are not homes.

Under current and past Administration on Aging (AOA) practices and procedures, these complaints and concerns of State Ombudsmen have not been resolved. The AOA refuses to evaluate and judge these complaints and leaves the Ombudsmen to his/her own solutions. The AOA is not willing or able to answer Ombudsmen complaints about there inability to adequately perform their mandated jobs.

Faced with these problems and history, many advocate an independent, separate home for the state LTCOP outside the state unit on aging. If state Ombudsmen are to effectively deal with the multitude of governmental laws, regulations, and policies affecting LTC residents, they must be free of even the appearance of conflict with all licensing, regulatory, and reimbursement agencies. Therefore, the placement of an independent state LTCOP depends on the statutory and political configuration of each state's government.

The major advantages of Michigan's placement with a non-governmental agency include:

(1) Strong assurances that Ombudsman work is a free, an independent voice of resident and consumer concerns and not those of "government" or the "industry;" and

(2) Strong ties to other non-governmental agencies concerned about LTC.

ADDING OF DUTIES TO THE LTCOP

Others have advocated adding to the list of LCTOP responsibilities non-institutionalized LTC services such as home health, respite care, homemaker, etc. While CBC and its state and local Ombudsman projects have looked at advocacy within those service delivery systems, I categorically oppose any increase in LTCOP responsibility without an appropriate increase in funding to meet those new responsibilities.

It is a disservice to the public and to the reputation of "government" to create a statutory duty for services without appropriating the funds necessary to carry out that service. The state LTCOPs have already once suffered that fate with the addition of board and care facilities without any increase in funds to answer requests for service for thousands of residents promised something by statute.

A second and equally important concern I have with the addition of non-institutionalized services is with real, not potential, conflict of interest it will raise. Evey state unit on aging and Area Agency on Aging (AAA) is intimately involved in the provision and delivery of these services. For state and local Ombudsman programs housed with or funded by the state unit or AAA, the public will rightly ask how can the independence of the Ombudsman's work be guaranteed. The addition will be seen as another complication factor in the Ombudsman's independence.

The conflicts of interests created by adding non-institutionalized services to LTCOPs must be thoroughly analyzed and resolved prior to adding the service area.

ADEQUACY OF CURRENT LTCOP FUNDING

For FY 1985, the Michigan LTCOP received $101,000 which provided 3.53 FTEs. The 1% of Michigan's Title IIIB funds accounted for approximately $86,000, with the remainder of the total coming from general state revenues.

The funding is not adequate to serve the 60,000+ residents of Michigan's 440 nursing homes, 130 homes for the aged, and an estimated 1000 Adult Foster Care Homes where the OAA mandates Omudsman services. Facilities in areas of the state without local Ombudsman projects are as far as 500 miles from the office of the Michigan LTCOP. Even with the consideration of the 5 of 14 local AAAs that fund local Ombudsman projects, the entire Michigan Ombudsman system had available less than $300,000 for the FY 1984 fiscal year.

Merely raising the $20,000 floor is not sufficient. The OAA language as to insuring an "effective" LTCOP must be actualized through increased funding. A raise in the percentage or a new formula based on the number of beds or other factors is in order. I would also recommend that the funding formula be improved with a federal incentive to states that put state revenues into the state LTCOP.

TECHNICAL ASSISTANCE TO LTCOP BY THE AOA

If I had provided the same quality and quantity of technical assistance and support to local Ombudsman projects of Michigan that the AOA has provided to me, I would not be state Ombudsman. I would hope that someone would have fired me or I would have had the grace to quit.

When I compare the technical assistance and support we have received from the OSA to AOA, I am convinced it is not a matter of government or bureacracy or money but of commitment to the work of the Ombudsman programs that separates the two.

I heartedly recommend that AOA be mandated to:

(1) Provide a timely summary of Ombudsman annual reports including statistical complaint data, state laws and regulations promulgated during the year, an accurate mailing list of all state LTCOPs, a description of each LTCOP's organization location and relationship to local projects, funding sources, and a list and description of the major long-term care concerns/issues identified by each LTCOP.

(2) Convene and fund a yearly conference of LTCOPs for training.

(3) Convene and fund regional meetings of LTCOPS and their staffs every six months.

(4) Maintain a clearinghouse on programmatic issues such as statistics gathering and interpretation, liability insurance, confidentiality and the subpeona of records, negotiation skills, state Ombudsman legislation, fundraising, etc.

(5) Contract out a clearinghouse on substantive LTC issues such as the impact of DRGs, certificate of need, medicaid discrimination in LTC, effective resident council development, nursing home reimbursement, etc. Substantive issues are clearly outside the interest and ability of the AOA to handle.

OMB CIRCULAR 122A

The existence of OMB Circular 122A with its broad, tenuous definition of lobbying is in conflict with the letter and spirit of the OAA Ombudsman's mandate for services to the nation's elderly living in LTC facilities. Many state and local Ombudsman programs have been and will be intimidated by the OMB's threat to future funding, non-profit tax status, charitable bulk mail permits, and other issues.

I strongly recommend that Congress clear the air on the applicability of Circular 122A and the advocacy services due seniors by state and local Ombudsman, in particular, and all OAA providers, generally.

I deeply appreciate the Subcommittee and you interest in the health and integrity of state LTCOPs. Please do not hesitate to call on me or other Michigan Ombudsmen or CBC staff for additional information.

Sincerely,

Hollis Turnham,
State Long-Term-Care Ombudsman.

Testimony of Jacqueline C. Walker, Connecticut State Ombudsman, Department on Aging

My name is Jacqueline Walker. I am the State Ombudsman with the Connecticut Department on Aging.

In 1975 I was hired by the Connecticut Department on Aging as the Ombudsman Program Specialist which was funded with $18,000 of Older American's Act money.

Because it was virtually impossible to maintain a viable advocacy program for nursing home patients with that amount of money, Connecticut's Department on Aging submitted an Ombudsman Bill (C.G.S. 17-135a-m) which on passage went into effect in 1977. The bill called for a State appropriation of $250,000 to establish an Ombudsman Office to be staffed by one State Ombudsman and five Regional Ombudsman. The Department has since hired a sixth Regional Ombudsman.

The Ombudsman Program in Connecticut is highly respected and well-known for the work it accomplishes and the complaints which it handles. All complaints are directed to our office and it is only when violations or infractions are uncovered that the Ombudsman refer the problem on to the appropriate regulatory agency. Connecticut also has a patient's bill of rights which was instituted in 1975.

The Ombudsmen are well trained and knowledgeable regarding nursing home laws and regulations. The majority of the complaints are resolved by the Ombudsmen without further referral. The Ombudsman Office works closely with the Department of Health Services, the Department of Income Maintenance and the State's Attorney. In addition, the State Ombudsman meets regularly with the Coordinator of the Commission on Long Term Care regarding problem issues relating to nursing homes.

The State Ombudsman actively participated on the Committee which promulgated regulations requiring that nurses aides complete a training program before being allowed to work in nursing homes. In addition, the State Ombudsman assisted in the revisions of the Public Health Code as it applies to nursing homes.

The Ombudsman statute stipulates the mandatory reporting of abuse, neglect, abandonment and exploitation by all nursing home personnel These reports are investigated by the Ombudsman and are, by law, referred to the State's Attorney.

Because Connecticut's Ombudsman program is state funded, we do not have some of the same problems as other states. Connecticut does, however, still receive and utilize the Federal Administration on Aging grant for Ombudsmen. I do feel, however, that many states are trying to establish and maintain a worthwhile program with very little Federal funding. I feel that the Ombudsman Program has never occupied a prominent place in the Administration on Aging, although it's mandate is crucial to residents of long term care facilities. In addition, the requirements placed on Ombudsmen continually increase without the increased federal funding. I feel strongly that the Ombudsman program should not be placed in a regulatory agency. This would definitely be a conflict of interest. The placement of the program in private agencies such as Legal Services, or independent agencies such as the Department on Aging is more acceptable inasmuch as those agencies are not part of the regulatory process.

In those situations where the Ombudsman Program does not have the freedom to act judiciously in the resolution of problems, I believe the Ombudsman Office should be moved. Certainly, as an independent agency the Office might have fewer constraints, unless there are state statutes limiting the functions of that office.

APPENDIX 2

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LONG-TERM CARE OMBUDSMAN PROGRAMS AUTHORIZED WITH THE OLDER AMERICANS ACT: KEY FACTS OF THIRTEEN INDEPENDENT PROGRAMS

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November 18, 1985

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LONG-TERM CARE OMBUDSMAN PROGRAMS AUTHORIZED UNDER THE OLDER AMERICANS ACT: KEY FACTS OF THIRTEEN INDEPENDENT PROGRAMS

The Older Americans Act requires each State agency on aging to establish and operate a long-term care ombudsman program. There are four main purposes to this program: (1) investigate and resolve resident complaints in nursing homes and other long-term care facilities; and monitor the implementation of Federal, State, and local laws and policies with respect to long-term care facilities; (2) establish procedures for the ombudsman to gain access to long-term care facilities and patients' records; (3) create a statewide reporting system to collect and analyze data relating to complaints and conditions in long-term care facilities; and (4) establish procedures that protect the identity of the complaint. The State may run the program directly, or through any public agency or private non-profit organization which is not an association (or affiliate) of long-term care facilities. According to the Administration on Aging (AoA), 41 States administer the program within the State agency on aging and 13 States administer the program independently, that is, outside the State agency on aging.

Congressional Research Service (CRS) staff telephoned the 13 independent ombudsman programs to find out how these programs operate and how they are administratively structured. The Alaska program currently operates under contract with the State agency on aging, but as of January 1, 1986, the program will be subsumed under the State agency on aging operations. Of the remaining 12 programs, 5 are located in private non-profit organizations (Colorado, Delaware, District of Columbia, Michigan, and Wyoming); 3 are located within the Governor's office (Montana, New Jersey, and South Carolina); 3 are located in an independent State agency or commission (Maine, Oregon, and Wisconsin); and 1 is located in an umbrella department of social and health services which also includes the State agency on aging (Washington).

The following five categories show the breakdown of different types of ombudsman programs.

1. Ombudsman Programs Located in Private, Non-profit Organizations

a. Colorado. Located in the Medical Care and Research Foundation under a 3 year contract with the State agency on aging. The Foundation has responsibility for hiring the ombudsman who receives supervision and direction from a staff member at the State agency on aging. The membership includes citizens, consumers, State office on aging staff, and providers. The purpose of the board appears to be strictly advisory and not policy-making. The Ombudsman program consists of the ombudsman and one staff assistant.

b. Delaware. Located in Supportive Community Services, Inc., under a yearly contract with the State agency on aging. From 1976-1981 the program was located within the Delaware Division of Aging. The president of Supportive Community Services hires and supervises the ombudsman. The ombudsman has a 15 member advisory committee which is made up of professionals and non-professionals who are invited to serve by the ombudsman. The committee meets quarterly and discusses issues and lobbying strategies.

The ombudsman has one-part time staffer who coordinates volunteers.

c. District of Columbia. Located in the Legal Counsel for the Elderly, a department of the American Association of Retired Persons (AARP), effective October 1, 1985. AARP hires the ombudsman. The ombudsman appears to operate relatively independent of the State agency on aging, but reports to the office on a monthly basis. The program has an informal advisory board which consists of members of other AARP and Legal Counsel for the Elderly committees.

There are three local ombudsman who handle complaints.

a. Michigan. Located in Citizens for Better Care (CBC), a consumer oriented non-profit group. CBC' Executive Director hires the ombudsman. CBC is a membership organization consisting of 1000 nursing home residents and family members. The membership elects a 21 member board of directors which includes lawyers, legal service representatives, teachers, auto workers, nurses, retirees, and the first Vice-President of the AFL/CIO. CBC by-laws prohibit nursing home personnel from becoming members of CBC.

Although CBC has all responsibility for the ombudsman program, it does work closely with the State agency on aging. The State agency on aging provides technical assistance and oversees ombudsman hiring. In addition, CBC must consult with the State agency on aging prior to any public position it takes, but CBC is free to disagree with the State agency's position.

b. Wyoming. Located in the Wyoming State Bar Association. The Executive Director of the State Bar hires and supervises the ombudsman, is responsible for policy and administrative decisions affecting the ombudsman program, and acts as the program's representative in dealings with the State agency on aging.

A liaison from the State agency on aging closely monitors the ombudsman program and reviews policy with the State Bar. According to the ombudsman, the State Bar's contract prohibits any interference by the State agency on aging, but in practice differences between the two parties are usually negotiated since the Commissioner on Aging has the option not to renew the State Bar's contract.

The program does not have any advisory or policy boards.

The ombudsman does not have any staff.

2. Ombudsman Programs Located Within the Governor's Office

a. Montana. Located in the Governor's Senior Office of Legal and Ombudsman Services. The Governor's office supervises and provides direction to the ombudsman and is responsible for policy decisions. A committee comprised of representatives from the Governor's office, the State agency on aging, and the Board of Visitors (an advocacy group within the Governor's office) hires the ombudsman and his assistant.

A subcommittee of the Governor's Council on Aging serves as the program's advisory board. The Governor appoints members of this Council which include representatives of the health care industry.

Administrative decisions are made by a staff member of the Board of Visitors with assistance from the State agency on aging.

b. New Jersey. Located in the Governor's Office of Institutionalized Elderly. The ombudsman is appointed by the Governor and receives supervision and direction from the Governor's Office on Policy and Planning.

The ombudsman is in the process of setting up a citizen's advisory board and a nursing home administrator's advisory board with members chosen by the ombudsman. The purpose of these boards is to provide feedback from the community and the nursing home industry.

The ombudsman's office investigates complaints of elderly persons in health-related institutions--nursing homes, residential health care facilities, and boarding homes that offer health services.

The ombudsman has a staff of 27 persons--3 attorneys, 1 paralegal, 10 clerical, and 13 investigative staff which include R.Ns and persons with law enforcement experience. The professional staff do not have civil service status and are hired by the ombudsman. The clerical staff are civil service employes.

c. South Carolina. The ombudsman program in South Carolina handles all health and human services complaints, including long-term care. The ombudsman has several assistant ombudsmen working beneath him of which one is a long-term care ombudsman. This long-term care ombudsman contracts with local ombudsman coordinators who have responsibility for recruiting volunteers.

The Governor appoints the ombudsman who, in turn, hires his staff of 12. All policy and administrative supervision and direction comes from the Governor's Office on Health and Human Services.

Prior to 1977, the ombudsman program was located in the Commission on Aging but was moved to Governor's office where it was felt it would have more authority and visibility.

3. Ombudsman Programs Located in an Independent State Agency

a. Maine. Located in the Maine Committee on Aging (MCoA), an independent citizen advisory board. The Governor appoints the Committee's 13 members who must be over 60 and come from all geographic regions in Maine. The Personnel Committee of the MCoA hires the ombudsman. The ombudsman receives policy direction from the Committee's leadership--one House and Senate member each--and personnel supervision from the Committee's director. In addition, five committee members serve on an advisory committee which sets the priority issues for the upcoming year.

b. Oregon. In 1985, the ombudsman's office was moved from the Governor's office to an independent State agency. The program has a seven-member citizen's advisory board whose members are appointed by the Governor. Board members have 4 year terms. The board nominates three persons to be the ombudsman; the Governor must appoint one. The ombudsman has job tenure; the Governor cannot fire him.

The ombudsman submits two reports to the legislature each year; meets monthly with the Governor. He does not report to anyone for supervision or direction. He has ultimate responsibility for policy and administrative decisions.

There are 18 local ombudsmen in Oregon who receive training from the ombudsman. These local ombudsmen are not required to report to the State ombudsman for supervision and direction; statutory authority gives them total control over their local jurisdiction. Oregon uses 101 volunteers for the State's 200 nursing homes. Volunteers must take a 3 month training course.

The State ombudsman has one and one-half staff.

c. Wisconsin. Located in the Board on Aging and Long-Term Care which is attached to the Department of Administration. The ombudsman is hired by and receives supervision and direction from the Board's executive director.

A seven-member policy board hires the Board's executive director. Members are appointed by the Governor and have staggered terms. Members all have long-term care background and include a senior citizen, a gerontology professor, representatives from consumer groups, the nursing home industry, and health maintenance organizations.

The program was formerly in Governor's Office, but was moved to an independent agency by the legislature in order to free the program from the political process.

The ombudsman has two and one-half staff.

4. Ombudsman Programs in Same Umbrella Agency as State Agency on Aging

a. Washington. Since 1983 the program has been located in the Division of Audit which is within the Department of Social and Health Services, but was formerly located in the State Bureau on Aging. The ombudsman is hired and supervised by the Division director. Policy and adminstrative decisions are made by the Division director.

The ombudsman has set up nine local advisory councils. Members include area agency on aging directors, senior citizens, and family members. The purpose of the councils is to provide feedback from the community, recruit volunteers, and lobby. Members volunteer their time or are asked to serve by the ombudsman.

The ombudsman does not have any staff.

5. Under Contract With State Agency on Aging, But to be Incorporated in State Agency of January 1986

a. Alaska. As of January 1, 1986, Alaska's ombudsman program will be merged with the State agency on aging (Older Alaskans Commission). Currently, it is located in the Association of Older Alaskans Programs through a contract with the Older Alaskans Commission. The Association is made up of the project directors of the 45 senior programs under the jurisdiction of the Older Alaskans Commission.

The seven-member Board of Directors is elected by the general membership of 45 project directors. The Board hires the ombudsman and bookkeeper. The ombudsman receives supervision and direction from Board. Policy is approved by the Board.

The ombudsman handles all complaints of persons over 60; complaints are not limited to long-term care.

The ombudsman has one assistant and one bookkeeper.

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STATE STATUTES ON NURSING HOME OMBUDSMEN AND PATIENTS' RIGHTS

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November 21, 1985

INTRODUCTION

This table is a compilation of state statutes on nursing home ombudsman and patients' rights.

Twenty-seven states have laws which specifically concern nursing home ombudsman, and thirty states have patients' rights statutes. Note, however, that these and the remaining states may use the regulatory process to deal with both of these subjects.

STATE LAW CITATIONS

ALABAMA :	Code of Alabama 1975, through 1985 Supplement Ombudsman: 22-5A-1
ARIZONA :	Arizona Revised Statutes Annotated, through 1985 Supplement Patient's Rights: 36-447.17
CALIFORNIA :	West's California Codes, through 1985 Supplement Ombudsman: Welfare and Institutions 9700, Patient's Rights: Health and Safety 1599
COLORADO :	Colorado Revised Statutes 1973, Through 1984 Supplement Patient's Rights: 25-1-120
CONNECTICUT:	Connecticut General Statutes Annotated, through 1985 Supplement Ombudsman: 17-135A, Patient's Rights: 19a-550
DELAWARE :	Delaware Code Annotated, through 1984 Supplement Patient's Rights; 16-1121
DISTRICT OF COLUMBIA :	District of Columbia Code, through 1985 Supplement Patient's Rights: 32-1304
FLORIDA :	Florida Statutes Annotated, through 1985 Supplement Ombudsman: 400.301, Patient's Rights: 400.022
GEORGIA :	Official Code of Georgia Annotated, through 1984 Supplement Ombudsman: 88-1901a, Patient's Rights: 88-1901b
ILLINOIS :	Illinois Annotated Statutes, through 1985 Supplement Patient's Rights: 111 1/2-4152-101
IOWA :	Iowa Code Annotated, through 1985 Supplement Ombudsman: 249B.31, Patient's Rights: 135C.14(8)
KANSAS :	Kansas Statutes Annotated, through 1984 Supplement Ombudsman: 75-5916
KENTUCKY :	Kentucky Revised Statutes, through 1984 Supplement Ombudsman: 194.030, 216.540, Patient's Rights: 216.510
LOUISIANA :	West's Louisiana statutes annotated, through 1985 Supplement Ombudsman: 40:2010.1

MAINE : Maine Revised Statutes Annotated, through 195 Supplement Ombudsman: 22.5108, Patient's Rights: 22.7921

MARYLAND : Annotated Code of the Public General Laws of Maryland 1957, through 1985 Supplement Ombudsman: 70B-4, 70B-5, Patients' Rights 19-343

MASSACHUSETTS : Massachusetts General Laws Annotated, through 1985 Supplement Ombudsman: 19A-27, Patient's Rights: 111-70E

MICHIGAN : Michigan Compiled Laws, through 1985 Supplement Ombudsman: 333.21763, Patient's Rights: 333.20201, 333.21765

MINNESOTA : Minnesota Statutes Annotated, through 1985 Supplement Patient's Right: 144.651

MISSOURI : Vernon's annotated Missouri Statutes, through 1985 Supplement Patient's Rights: 198.088

NEVADA : Nevada Revised Statutes, through 1983 Supplement Ombudsman 427A.125, Patient's Rights: 449.700

NEW HAMPSHIRE : New Hampshire Revised Statutes Annotated, through 1985 Ombudsman: 167A:21, Patient's Rights: 151:21

NEW JERSEY : New Jersey Statutes Annotated, through 1985 Supplement Ombudsman: 52: 27G1, Patient's Rights: 30:13-5

NEW YORK : McKinney's Consolidated Laws of New York, through 1985 Supplement Ombudsman: Executive Law 544, Patient's Rights: Public Health 2803-C

NORTH CAROLINA : The General Statutes of North Carolina, through 1985 Supplement Ombudsman: 131E-128, Patient's Rights: 131E-115

NORTH DAKOTA : North Dakota Century Code, through 1985 Supplement Ombudsman: 50-10.1, Patient's Rights: 50-10.2

OHIO : Page's Ohio Revised Code, through 1984 Supplement Ombudsman: 173.01(m), Patient's Rights: 3721.10

OKLAHOMA : Oklahoma Statutes Annotated, through 1985 Supplement Ombudsman: 63-1-1902, Patient's Rights: 63-1-1918

OREGON : Oregon Revised Statutes, through 1983 Supplement Ombudsman: 441.100, Patient's Rights: 441.600

RHODE ISLAND : General Laws of Rhode Island, through 1985 Supplement Ombudsman: 23-17.5-12, Patient's Rights: 23-17.5-1

SOUTH CAROLINA : Code of Laws of South Carolina 1976, through 1985 Supplement Ombudsman: 43-38-10

TEXAS : Vernon's Annotated Revised Civil Statutes of Texas, through 1985 Supplement Patient's Rights: Human Resources 102.001

UTAH : Utah Code Annotated, through 1985 Supplement Ombudsman: 63-26a-1

VIRGINIA : Code of Virginia 1950, through 1985 Supplement Patient's Rights: 32.1-138

WASHINGTON : Revised Code of Washington, through 1986 Supplement Ombudsman: 43.190.010, Patient's Rights 74.42.010

WISCONSIN : West's Wisconsin Statutes, through 1985 Supplement Patient's Rights: 50.09

WYOMING : Wyoming Statutes, through 1985 Supplement Ombudsman: 9-2-1301

CRS- 5

	Ombudsman	Posting Requirements in Facilities	Reporting Requirements	Access to Facilities	Access to Records	Training	Confidentiality	Patient Rights
ALABAMA	X			X	X	X	X	
ARIZONA								X
CALIFORNIA	X	X	X 1/	X	X	X	X	X
COLORADO								X
CONNECTICUT	X	X	X 2/	X	X	X		X
DELAWARE								X
DISTRICT OF COLUMBIA								X
FLORIDA	X	X	X 3/	X			X	X
GEORGIA	X	X	X 4/	X	X	X	X	X
ILLINOIS								X
IOWA	X		X 5/	X	X	X	X	X
KANSAS	X		X 6/	X	X		X	
KENTUCKY	X	X	X 7/	X		X		
LOUISIANA	X			X	X	X	X	
MAINE	X		X 8/	X	X		X	X
MARYLAND	X							X
MASSACHUSETTS	X		X 9/	X	X	X	X	X
MICHIGAN	X			X			X	X
MINNESOTA								X
MISSOURI								X
NEVADA	X			X	X			X
NEW HAMPSHIRE	X		X 10/	X	X		X	X
NEW JERSEY	X	X	X 11/	X	X	X	X	X
NEW YORK	X	X		X	X	X	X	X
NORTH CAROLINA	X			X		X	X	X
NORTH DAKOTA	X	X		X	X	X	X	X

	Ombudsman	Posting Require-ments in Facilities	Reporting Require-ments	Access to Facilities	Access to Records	Training	Confiden-tiality	Patien Right
OHIO	X							X
OKLAHOMA				X[13]				X
OREGON	X	X		X	X		X	X
RHODE ISLAND				X[14]			X[14]	X
SOUTH CAROLINA	X				X			
TEXAS								X
UTAH	X			X	X		X	
VIRGINIA								X
WASHINGTON	X	X	X[12]	X		X	X	X
WISCONSIN								X
WYOMING	X			X		X	X	

Legend

1/ Reports to Governor, Legislature, California Commission on Aging, California Seniors Legislature, Area Agencies on Aging, Licensing Authorities for Long-Term Care Facilities

2/ Reports to General Assembly, Governor

3/ Reports to President of Senate, Speaker of the House, Governor

4/ Reports to Office of Special Programs

5/ Reports to General Assembly

6/ Reports to Legislature, Governor, Secretary of Aging

7/ Reports to General Assembly

8/ Reports to Director Bureau of Maine's Elderly, Commissioner Maine's Human Services, Governor, Legislature

9/ Reports to Secretary of Elderly Affairs, Governor, General Court

10/ Reports to State Council on Aging

11/ Reports to Governor, Legislature

12/ Reports to Governor, Legislature, Federal Commission on Aging, Any Area Agencies on Aging, Department of Social and Health Services

13/ The Definition of Access as Used in the Nursing Home Care Act includes Ombudsman

14/ Access to facilities and confidentiality is provided through the patient's rights law.

Mark Gurevitz

Mark Gurevitz
Legislative Research Assistant
American Law Division
November 21, 1985

Congressional Research Service
The Library of Congress

Washington DC 20540

November 15, 1985

TO : House Select Committee on Aging
Attention: Bente Cooney

FROM : Carol O'Shaughnessy
and
Richard Price
Specialists in Social Legislation
and
Susan Schillmoeller
Technical Information Specialist
Education and Public Welfare Division

SUBJECT : Selected State Data on Older Americans Act Long-Term Care Ombudsman Program; State Data on Number of Nursing Home Residents and Beds

Per your request, attached is a table presenting selected data on the long-term care ombudsman program and the number of nursing home residents and homes, by State. (Data has not been included for Puerto Rico, American Samoa, Guam, the Virgin Islands, the Trust Territories, or the Northern Mariana Islands.) Following is a brief description of the data and data sources.

Column #1. Organizational Placement of State Ombudsman Programs. The majority of ombudsman programs are located in the State agency on aging. Excluding programs in the outlying areas, the chart shows that in 39 States, the ombudsman program is located in the State agency on aging. In five States, the ombudsman program is located in private, non-profit organizations; in three States, in the Governor's office; in three States, in an independent State agency or commission; and in one State, in an umbrella agency which also includes the State agency on aging. (NOTE: For purposes of this chart the Alaska program is shown as being located in the State agency on aging; this organizational placement is effective as of January 1986.)

Source: Information on programs in State agencies on aging is from the Administration on Aging (AoA); CRS verified those programs which are located outside State agencies on aging, as indicated by AoA.

Column #2. Sub-State Ombudsman Staff/Volunteers. According to the 1982 AoA ombudsman report, 43 States indicated that there were ombudsman staff or volunteers at the sub-State level. We contacted those States which in 1982 indicated that they did not have sub-State staff or volunteers to verify if this was still the case--Maine, New Hampshire, New Jersey, Delaware, Iowa, South Dakota, Hawaii, and Alaska. Of those which have responded so far, 2 States (New Hampshire and Hawaii) indicated that they now have staff or volunteers working on the ombudsman program at the sub-State level. The new total of States in this category is 45. We have not yet been able to obtain updated information on Iowa. We did not contact the 43 States which had sub-State staff/volunteers in 1982 to determine if they still had such programs. It should be pointed out that although a State may not indicate that it has sub-State staff/volunteers, it may use other means to provide ombudsman services throughout the State; for example, a State agency may use State agency personnel to provide sub-State services under a centralized system.

Source: AoA Information Memorandum 84-11, National Summary of State Ombudsman Reports for U.S., FY 1982, Table 5, Staffing: State and Local Ombudsman Programs, selectively updated.

Columns #3 and 4. FY 1985 Title III-B Supportive Services Allotment and One Percent of Supportive Services Allotment, Whichever is Greater. Section 307(a)(21) of the Older Americans Act requires each State agency to set aside at least one percent of its title III-B supportive services allotment, or $20,000, whichever is greater, to support the State ombudsman program as required under section 307(a)(21) of the Act. If the State meets this dollar equivalent from State and/or local funds, it is not required to use the title III-B funds for this purpose. (NOTE: This requirement does not apply to American Samoa, Guam, the Virgin Islands, the Trust Territories, and the Commonwealth of the Northern Mariana Islands.) According to AoA, in FY 1984, three States used no title III-B funds to support their ombudsman programs (Alaska, New Jersey, and Virginia). Other States may use a combination of State and local funds, and Federal title III-B and title IV funds.

Columns #3 and 4 show only the Federal title III-B supportive services allotment for FY 1985, and one percent of the State allotment, or $20,000, whichever is greater. Therefore, these data only give an indication of the Federal dollar requirement, not how much each State is actually spending. As we discussed last week, AoA is currently compiling total expenditures by States on the ombudsman program for FY 1984.

Column #4 shows that in 1985, 17 States would be required to spend at least $20,000 to meet the Older Americans Act requirement since one percent of their 1985 allotment would be lower than the minimum amount.

Source: FY 1985 allotments, AoA; one percent of allotments calculated by CRS

Columns #5, 6, and 7. Data on Number of Nursing Homes, Nursing Home Residents, and Beds per 1000 Population 65 Years and Over. These columns show State data on the number of nursing homes and nursing home residents, and the number of beds per 1000 population 65 years and over for 1982. In 1982 there were almost 18,000 nursing homes with about 1.4 million residents of all ages. The number of nursing homes in the States ranged from a low of 12 in Alaska to a high of 1,176 in California. Similarly, the number of residents ranged from 871 in Alaska to 105,773 residents in New York. The lowest number of beds per

1000 population age 65 years and over was in New Mexico with 22.4 beds per 1000 population compared with 97.2 beds per 1000 population in Iowa.

Source: Unpublished 1982 data from the National Master Facility Inventory Survey of Nursing and Related Care Homes, National Center for Health Statistics (NCHS). The definition of nursing home used by NCHS is that a home must maintain three or more inpatient beds, and, at a minimum, must provide one or more personal care services (such as help with eating, walking, correspondence, shopping, dressing, bathing, or massage).

Attachment

SELECTED DATA ON THE LONG-TERM CARE OMBUDSMAN PROGRAM UNDER THE OLDER AMERICANS ACT; DATA ON NURSING HOMES AND RESIDENTS, BY STATE a/

	(1) Organizational placement of State ombudsman programs					(2) Sub-State ombudsman, staff/ volunteers 1982 b/		(3)	(4)	(5)	(6)	(7)
	State agency on aging (SAA)	Governor's office	Private non-profit organization	Independent State commission/ agency	In same umbrella agency as SAA	Yes	No	Title III-B supportive services allotment, FY 1985	1 percent of title III supportive services allotment, or $20,000, whichever, is greater, FY 1985	Number of nursing and related care homes, 1982	Number of residents in nursing homes and related care homes, 1982	Beds per 1000 population 65 years and over, 1982
Total	39	3	5	3	1	45	6	--	--	17,819	1,378,702	56.2
Alabama	X					Y		$ 4,263,077	$ 42,631	191	19,113	44.5
Alaska	X c/						N	1,386,245	20,000	12	871	80.7
Arizona	X					Y		3,209,515	32,095	143	9,181	30.7
Arkansas	X					Y		2,945,226	29,452	202	17,853	59.8
California	X					Y		24,347,688	243,477	1,176	99,805	41.4
Colorado			X			Y		2,572,634	25,726	158	15,053	64.2
Connecticut	X					Y		3,706,937	37,069	337	26,659	71.7
Delaware			X				N	1,391,760	20,000	36	2,136	36.3
District of Columbia			X			Y		1,392,499	20,000	45	2,419	37.1
Florida	X					Y		16,236,903	162,370	306	39,218	23.8
Georgia	X					Y		5,180,031	51,800	335	30,615	58.2
Hawaii	X					Y		1,394,874	20,000	222	2,633	31.9
Idaho	X					Y		1,395,703	20,000	48	3,787	40.8
Illinois	X					Y		12,229,877	122,299	849	91,462	76.1
Indiana	X					Y		5,707,996	57,080	477	61,889	71.8
Iowa	X						N d/	3,608,863	36,088	540	35,517	97.2
Kansas	X					Y		2,900,730	29,007	364	23,556	82.7
Kentucky	X					Y		3,928,756	39,288	302	26,038	61.8
Louisiana	X					Y		3,978,027	39,780	225	23,661	59.1
Maine				X			N	1,615,679	20,000	430	11,305	81.7
Maryland	X					Y		4,115,964	41,159	204	20,670	51.2
Massachusetts	X					Y		6,929,233	69,292	779	49,900	70.6
Michigan			X			Y		9,081,267	90,812	501	51,753	58.1
Minnesota	X					Y		4,513,525	45,135	417	40,555	85.9
Mississippi	X					Y		2,752,697	27,527	165	12,967	44.7
Missouri	X					Y		5,987,786	59,878	827	43,739	75.7
Montana		X				Y		1,394,516	20,000	65	4,555	57.9
Nebraska	X					Y		1,968,247	20,000	263	17,075	90.2
Nevada	X					Y		1,394,038	20,000	35	2,230	33.8
New Hampshire	X					Y		1,396,512	20,000	89	6,630	64.3
New Jersey		X					N	8,598,031	85,980	467	36,616	43.1
New Mexico	X					Y		1,399,090	20,000	76	2,567	22.4
New York	X					Y		20,556,339	205,563	944	105,773	51.0
North Carolina	X					Y		6,134,537	61,345	886	29,709	49.0
North Dakota	X					Y		1,393,387	20,000	85	6,215	77.4

Footnotes shown on next page.

SELECTED DATA ON THE LONG-TERM CARE OMBUDSMAN PROGRAM UNDER THE
OLDER AMERICANS ACT, DATA ON NURSING HOMES AND RESIDENTS, BY STATE--Continued a/

	(1) Organizational placement of State ombudsman programs					(2) Sub-State ombudsman staff/ volunteers 1982 b/		(3)	(4)	(5)	(6)	(7)
	State agency on aging (SAA)	Governor's office	Private non-profit organization	Independent State commission/ agency	In same umbrella agency as SAA	Yes	No	Title III-B supportive services allotment, FY 1985	1 percent of title III supportive services allotment, or $20,000, whichever is greater, FY 1985	Number of nursing and related care homes, 1982	Number of residents in nursing homes and related care homes, 1982	Beds per 1000 population 65 years and over, 1982
Ohio	X					Y		11,567,730	115,677	926	68,861	62.1
Oklahoma	X					Y		3,508,201	35,082	365	25,056	74.5
Oregon				X		Y		3,010,653	30,106	196	14,662	69.5
Pennsylvania	X					Y		15,051,611	150,516	552	61,639	40.5
Rhode Island	X					Y		1,399,186	20,000 —	109	8,538	69.0
South Carolina		X				Y		3,028,566	30,286	193	11,751	39.6
South Dakota	X						N	1,394,667	20,000 —	139	7,812	86.8
Tennessee	X					Y		5,013,844	50,138	257	24,079	48.5
Texas	X					Y		13,622,307	136,223	1,019	84,043	72.5
Utah	X					Y		1,398,117	20,000 —	80	4,581	43.4
Vermont	X					Y		1,390,910	20,000 —	159	3,995	71.0
Virginia	X					Y		5,186,788	51,868	443	20,223	58.4
Washington					X	Y		4,351,037	43,510	400	20,199	67.7
West Virginia	X					Y		2,346,800	23,468	169	7,614	33.2
Wisconsin				X		Y		5,352,754	53,528	508	46,904	86.0
Wyoming			X			Y		1,388,927	20,000 —	21	1,922	53.8

17 states use the $20,000 minimum

a/ See accompanying memo for notes and sources.

b/ Data is from the AoA National Ombudsman Summary Report which has been selectively updated. See accompanying memo.

c/ Located in the State agency on aging beginning January 1, 1986; prior to that date, located in Association of Older Alaskan's Programs, an association made up of project directors of Alaska's senior programs.

d/ For the 1982 AoA National Ombudsman Summary Report, Iowa did not have sub-State staff of volunteers; updated information is not yet available.

Carol O'Shaughnessy
Richard Price
and
Susan Schillmoeller
Congressional Research Service
Education and Public Welfare Division
November 15, 1985

STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
AUGUSTA, MAINE 04333

JOSEPH E. BRENNAN
GOVERNOR

MICHAEL R. PETIT
COMMISSIONER

November 27, 1985

Honorable Mario Biaggi, Chairman
Select Committee on Aging
Subcommittee on Human Services
US House of Representatives
716 House Office Bldg., Annex I
Washington, D.C. 20515

Dear Congressman Biaggi:

I wish to add my comments to what are apparently ongoing discussions about the placement of the ombudsman program under the Older American Act. I regret that I am not more timely in my submission of formal testimony, although I certainly concur with the statement of the National Association of State Units on Aging presented at your hearing. Unfortunately I have only now had a chance to study testimony presented to you by Maine's Ombudsman, Jill Duson, in a witten document she forwarded to you on October 3, 1985. I believe further clarification is important.

Maine has a strong and effective ombudsman program subcontracted to the Maine Committee on Aging, which I wholly support. I agree with Jill Duson that "The physical location of the ombudsman program within or outside the state unit on aging is not the issue upon which our attention should be focused" and that the model we have established here in Maine is a strong one. However I must take exception to a few other points.

My perspective is based on my role as a state agency director and from my earlier role with the ombudsman program. Working with other ombudsman and the Legal Research and Services for the Elderly program I was responsible for drafting for Senator Hathaway the original language establishing the ombudsman program within the Older Americans Act.

If one reviews that original legislation it is quite clear that the intent of the program was to focus primary advocacy on investigating and resolving complaints. Certainly there were other equally important issues spelled out in the law including monitoring the development and implementation of laws and regulations, providing information regarding the problems of older individuals in long term care facilities and providing training for staff and volunteers to promote the development of citizen organizations. But I do believe that the original legislation saw complaint mechanism as a key role and not a "band-aids solution" as Ms. Duson suggests. She suggests the ombudsman program must be more focused on systems change. Placement of the ombudsman program as a state plan requirement made clear that it was the responsibility of the state agency as a whole not just the ombudsman program to conduct the kind of advocacy to create system change. It is important to recall the integral relationship of the state unit and the ombudsman program. The ombudsman program provides the technical expertise, through individual complaint resolution, of identifying specific policy issues within the nursing home program. To minimize the critical nature of complaint investigation as a means to best understand and resolve the problems of nursing homes is to me a major step away from a primary function of a long term care ombudsman. Similarly I believe the Older Americans Act spells out a very clear role for the state unit in advocating for change identified by the ombudsman and working closely with the ombudsman. State agencies, no matter how they structure an ombudsman program, must continue to be held responsible for long term care advocacy and program development. A totally independent ombudsman could minimize the state agency's capacity to so respond and could in many states weaken the ombudsman and minimize available resources.

It is true that in Maine we have subcontracted our program to a separate and distinct advocacy agency, the Maine Committee on Aging, with whom I was formerly employed. I concur with Ms. Duson that that works extremely well in our state but I would not suggest, nor did I in my earlier advocacy to create the ombudsman program, that what works here in Maine will work in other states. Curiously, Ms. Duson suggests that it is important for the designated state ombudsman to have direct access to the state unit on aging's director. In fact if the ombudsman program was housed within our bureau, that would undoubtably be the case. However, as it is and will continue to be subcontracted, the ombudsman must report first to her lines of authority within her agency before having access to me. This lack of access by the ombudsman to the state director is because we subcontract to another agency with its own line of authority.

I sincerely believe that each state needs to make its own decisions about where best an effective ombudsman program can be housed. Certainly the federal government ought to spell out the specific responsibilities of that ombudsman program to assure that its tasks are properly met. I view the ombudsman program as integral to the state unit on aging's mission as an advocate to create system reform in long term care and in other programs. It is the program through which state agencies - either directly or through subcontract - meet a most critical obligation to serve the most frail elderly. If there are problems within state units on aging in their effectiveness in meeting their obligation to establish an ombudsman program then those problems ought to be carefully analyzed and AoA ought to take action to remedy them. Since the ombudsman program is created as part of the state plan the Administration on Aging has significant clout in improving the ombudsman program. Should a state be out of compliance with congressional intent then the Administration on Aging has the authority to deny or withhold approval of the state plan. Since this is a critical document bringing all OAA funds to a state I would argue that AoA has significant authority to insure that the Congress's intent is met.

I deeply regret the need to state a position different from that of the Maine Committee on Aging and Ms. Dusen. However we both agree that the Maine Committee on Aging's ombudsman program is an extraordinarily valuable and strong one which works exceptionally well here in the state of Maine. I am simply unwilling to suggest that because it works here in Maine it can be transferred elsewhere. I believe mandating a particular placement in federal law which each state must meet would be in error.

Thank you,

Trish Riley

Trish Riley, Director
Bureau of Maine's Elderly